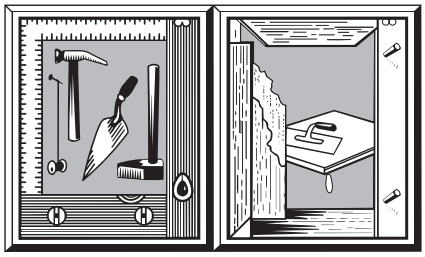

BAC Local Union 15 Welfare Fund

Restated Plan Document &
Summary Plan Description
April 2023

BAC LOCAL UNION 15 WELFARE FUND

RESTATED PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

Restated April 2023

Be a Smart Health Care Consumer

Following the suggestions listed below will not only save the Plan money, but they will also save you money.

Top Ways to Save

1. Utilize healthcare providers in the BlueKC / BCBS PPO network when possible. Visit www.mybluekc.com or call (800) 810-2583 for a current list of network providers.

2. Enroll in Medicare as soon as you are eligible for Part A and Part B coverage.

3. Utilize the mail order prescription services for maintenance drugs that you take on an on-going basis. You should also inquire about the cost of any prescribed medications. Generic drugs often cost much less than name brands and your Physician can prescribe them if you ask. If you have any questions about mail order, specialty drugs, or the Plan's preferred brand drug formulary, please contact Sav-Rx at www.savrx.com or by phone at (866) 912-7425.

4. Review your copy of all provider billings and explanation of benefits ("EOB's") to make sure you received the services listed. Question all discrepancies.

5. Save the emergency room for real Emergencies. If you need non-emergency same day care outside the office hours of your Physician, consider utilizing the BlueKC Virtual Care Telehealth, Virtual PPO doctor visits, or an urgent care facility.

6. Enroll in the BlueKC Well and High Risk Prenatal Program when you discover you are pregnant. Visit MyBlueKC.com to learn more about the program.

7. Ask your provider to request prior authorization from BlueKC when you need to be admitted to a Hospital, are having surgery, need Durable Medical Equipment, Home Health Care, Hospice care or Skilled Nursing Facility services. While not all such services require prior authorizations, by requesting the prior authorization you could avoid any conflict that may occur by receiving a service that is not covered by the Plan.

8. If a third party could be responsible for your medical services, (i.e. automobile coverage, workers compensation, home owners insurance), be sure to make the Fund office aware of the other liability and utilize the Plan's subrogation rules.

9. Maintain a healthy lifestyle. Many illnesses and injuries can be prevented. Major illnesses such as heart disease are often connected with lifestyle. Smoking, excessive drinking of alcoholic beverages, improper diet, and stress are a few of the factors that can cause heart disease. By eating right, getting enough sleep, and exercising regularly, you can prevent or moderate many illnesses.

A Letter From Your Board of Trustees

Dear Participants and Beneficiaries:

We are pleased to distribute this new restated, combination Plan Document and Summary Plan Description (benefit booklet) describing the Benefits provided under your Plan. If you do not see the information you are seeking in this booklet, please contact the Fund Office.

This booklet contains the general Plan provisions, Eligibility Rules for participation in the Plan, the Benefits provided to those who are eligible, and the procedures which must be followed when filing a claim for Benefits.

There have been a number of changes to the Plan since the last booklet was distributed. As a result, you should **READ THIS BOOKLET CAREFULLY** so that you are up to date on the current Plan rules and Benefits.

From time to time, other changes and improvements to the Plan may be made. When this occurs, we will make every attempt to advise you of them. In order to assist us in keeping you up to date, **IT IS YOUR RESPONSIBILITY TO KEEP THE FUND OFFICE INFORMED OF YOUR CURRENT HOME ADDRESS AT ALL TIMES.** This is the only way to be sure that you receive notice of any Plan changes.

This is your copy of the booklet describing your Plan. Please take the time to read it in its entirety and refer to it when you have any questions about the Plan. You should keep this booklet in a safe (but handy) place for future reference. If at any time you have questions about the Plan, please feel free to call or write the Fund Office at:

BAC Local Union 15 Welfare Fund
PO Box 909500
Kansas City, MO 64190-9500
(816) 777-2668 or (833) 479-9428

http://www.bac15benefits.org/

We look forward to serving you.

The Board of Trustees or designated Committee shall have the full discretion and authority to interpret, amend, construe and apply all terms of the combined Plan Document and Summary Plan Description (SPD), the Amended Trust Agreement and/or any rules and regulations established by the Board of Trustees including, but not limited to, provisions concerning eligibility for, entitlement to and/or nature of amount and duration of benefits, in reaching a decision on the Claimant's request for review of the denial of the claim.

The decision of the Board is final.

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Board of Trustees

Management Trustees

Gregory S. Davey
The Builders Association
720 Oak Street
Kansas City, MO 64106

Bill Lipp
J.E. Dunn Construction Company
1001 Locust Street
Kansas City, MO 64106

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Dustin Himes
BAC Local Union 15
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About Your Plan

Today a working person's life is far more complicated than ever before. In addition to the responsibilities of getting and holding a job, most workers are vitally concerned about planning for some degree of financial security in a fast moving world.

Some of a family's needs such as the purchase of a home, major appliances or a car can be financed over time. Other needs, such as education for the children or security in one's old age, can be provided only through a careful savings plan. In other words, advance planning is required in order to take care of these needs.

However, no amount of personal financial planning can, by itself, provide adequate protection for major financial problems caused by sickness or injury.

To help meet these needs, for you and your fellow workers, your Employer and the Union have established a Plan, which provides a specific, dependable plan of health and welfare benefits. Since its beginning in 1973, the Plan has been managed to provide the best possible benefits consistent with sound financial management.

The Plan, known as the BAC Local Union 15 Welfare Plan, was established and is maintained as a result of Collective Bargaining Agreements (sometimes referred to as "labor contracts") between The Builders' Association and the Union.

The Plan receives the majority of its income through Employer contributions as required under the terms of the Collective Bargaining Agreements. In some cases, Employees are permitted to make self-contributions in order to maintain eligibility for Benefits. The Plan also receives income from investments.

The Plan is self-funded for all benefits except for Medicare Retirees where benefits are provided by a group Medicare Advantage with Part D (MAPD) program. When Employees work in covered employment, the Employer makes contributions to the Fund on the Employee's behalf, as required by collective bargaining agreements. These contributions are used to pay Benefits and administer the Plan on the Participant's behalf.

Decisions on Plan operations are made by a joint Board of Trustees which is comprised of an equal number of Employer representatives and Union representatives. Working together, the Trustees establish rules of eligibility, levels of benefits, supervise the investment of the Plan's money and see that the Fund is in compliance with all applicable federal and state laws.

This, then, is a brief description of how your Plan was established, its purpose and how it operates. The following pages describe how you and your family become eligible for Benefits from the Plan and what your responsibilities are under the Plan. Of course, if you have any questions about the Plan, please feel free to contact the Fund Office. The staff will gladly answer your questions.

Filing an Enrollment Card

IF YOU HAVE NOT FILED AN ENROLLMENT CARD, DO SO NOW!

When you first became employed under the terms of the Collective Bargaining Agreement, you should have received an **"ENROLLMENT CARD"** from either the Union or the Fund Office.

This card requests certain basic information that is needed for your records in the Fund Office. This information is your full legal name and the full legal names of all of your Eligible Dependents, your address, your Social Security number and the Social Security number of all of your Eligible Dependents, if applicable, your date of birth and the dates of birth of all of your Eligible Dependents, and the name of your Beneficiary(ies) in the case of your death.

All of this information is vital! Without it, the Fund Office will have difficulty knowing what you and your family are entitled to under the Plan and in keeping you informed about Plan changes.

If you are not sure whether you have an enrollment card on file at the Fund Office, contact the office. The staff will tell you whether you have a card on file and verify that it contains current information. If you do not have current information on file, a card will be sent to you for completion and return.

NOTIFY THE FUND OFFICE PROMPTLY WITH ANY CHANGE IN ADDRESS, BENEFICIARY, DEPENDENTS, MARITAL STATUS, MEDICARE OR RETIREMENT ELIGIBILITY.

When there are Plan changes, you will be sent notice of the change. This means that, in order to notify you, the Fund Office must have your current address. **IF YOU MOVE**, make sure to notify the Fund Office of your new address. **IF YOUR MARITAL STATUS CHANGES,** don't forget to notify the Fund Office. The Fund Office must receive a complete, signed and dated copy of your marriage certificate, divorce decree or Order of Legal Separation. These documents will be made a permanent part of your file and will be kept in the Fund Office. Failure to send copies of these documents will delay the processing of claims for Benefits.

If you wish to **CHANGE THE NAME OF YOUR BENEFICIARY, DON'T FORGET TO SEND THE CHANGE TO THE FUND OFFICE, IN WRITING.** If you fail to notify the Fund Office of your wishes in writing, the Fund Office will be unable to pay any Death Benefits to anyone other than the person(s) in your latest **written** notification to the Fund Office prior to the time of your death.

If you need to **ADD OR DELETE DEPENDENTS,** you must notify the Fund Office, **in writing**. You should be prepared to provide documentation in the form of a birth certificate, decree of adoption, marriage license, etc. Since the Plan provides Benefits to Eligible Dependents, the Fund Office must know who your dependents are at all times.

If the Plan makes any inadvertent, mistaken or excessive payments of Benefits, the Trustees or their representatives shall have the right to recover the payments.

A Word about Confidential Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides stringent requirements for the Fund, its Trustees and its service vendors concerning the use and disclosure of Participants' personally identifiable 'Protected Health Information' (PHI). Broadly speaking, PHI includes demographic information about you and/or your dependents, such as your name, address, telephone number and Social Security Number, in conjunction with information concerning you and/or your dependents, such as: (1) eligibility for Benefits, (2) medical treatment provided or (3) payment for such medical treatment. Specifically, the Plan will use and disclose PHI only for purposes related to health care treatment, payment for health care and health care operations.

The Plan's use and disclosures of PHI is set out in detail in the Privacy Notice previously mailed to you. If you would like another copy of this notice, please contact the Fund Office.

The Plan and the Trustees are committed to observing these privacy rules and in ensuring the confidentiality of your PHI. Your cooperation and understanding in working with the Plan to achieve compliance with these federal requirements is appreciated.

Section One – Schedule of Benefits

The Plan offers benefits to the following groups of Participants:

A. Active Eligible Employees and Eligible Dependents

B. Retired Participants Not Eligible for Medicare and their Eligible Dependents

C. Retired Participants and Eligible Dependent spouses eligible for Medicare

FOR PARTICIPANTS IN GROUPS A AND B: EXCEPT WHERE OTHERWISE INDICATED, THE SCHEDULE OF BENEFITS DESCRIBED IN THIS DOCUMENT APPLY TO ALL OF THE PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS.

FOR PARTICIPANTS IN GROUP C: BENEFITS FOR RETIREES AND SPOUSES ELIGIBLE FOR MEDICARE ARE PAID UNDER THE PLAN'S GROUP MEDICARE ADVANTAGE WITH PART D ("MAPD") PROGRAM. ANY MEDICARE-ELIGIBLE PARTICIPANT COVERED BY THIS PLAN WHO ENROLLS IN AN OUTSIDE MEDICARE SUPPLEMENT OR PART D PLAN WILL LOSE THEIR COVERAGE UNDER THIS PLAN.

The Fund has negotiated special contracts with a network of area Physicians and Hospitals known as a Preferred Provider Organization (PPO). These participating providers will render services for fees that, in most cases, are below prevailing prices. Providers that are *in* this network are referred to as In-Network. Providers that are *not in* this network are referred to as Out-of-Network. If the Covered Person uses an In-Network provider, the Fund will pay 90% of all allowed charges and the Covered Person will pay the remaining 10%. If the Covered Person uses an Out-of-Network provider, the Fund will pay 70% of all allowed charges and the Covered Person will pay the remaining 30%, unless such claim is covered under the No Surprises Act, as discussed in Section 12, subsection K of this Plan.

IN-NETWORK SERVICES	**FUND PAYS 90%** **YOU PAY 10%**
OUT-OF NETWORK SERVICES	**FUND PAYS 70%** **YOU PAY 30%**

There is no Major Medical Benefit Lifetime limit. There are no annual maximums. In addition, the calendar year deductible is $300 per person / $600 per family when an In-Network provider is used. When an Out-of-Network provider is used, the calendar year deductible is $500 per person / $1,000 per family.

ANNUAL MAXIMUM	**NO ANNUAL MAXIMUMS**
ANNUAL DEDUCTIBLE	
IN-NETWORK	**$300 (PERSON) / $ 600 (FAMILY)**
OUT-OF NETWORK	**$500 (PERSON) / $1,000 (FAMILY)**

The maximum Out-of-Pocket Limit per family is $7,500 per calendar year. This Out-of-Pocket Limit applies only to allowed charges. Once the Out-of-Pocket Limit has been reached within a calendar year, allowed charges in that year will be paid at 100% of allowed charges up to the Benefit maximum. The Out-of-Pocket Limit does not apply to all benefits. Please see the table beginning on page 31 for a detailed listing of which benefits do not apply to your annual Out-of-Pocket Limit.

ANNUAL OUT-OF-POCKET (PER FAMILY)	**$7,500**

Some Benefits are only available to certain individuals. Please refer to Section Fifteen for clarification between Participant, Covered Person, Covered Employee and Eligible Dependent.

YOU ARE NOT REQUIRED TO USE AN IN-NETWORK PROVIDER. COMPLETE FREEDOM OF CHOICE IS YOURS. HOWEVER, CHOOSING AN IN-NETWORK PROVIDER FOR YOUR HEALTH CARE NEEDS WILL SAVE YOU AND THE FUND MONEY.

All Covered Persons are covered by the BlueCross BlueShield of Kansas City Network. For the most up-to-date provider information for BlueCross BlueShield of Kansas City (BlueKC), you can visit BlueKC's website at www.bluekc.com or contact the Provider Finder at (800) 810-BLUE (2583). You may also call the Fund Office at (816) 777-2668 or toll free at (833) 479-9428.

If you rely on information in the Plan's provider directory that inaccurately states that an Out-of-Network provider is In-Network, you will only be subject to the Plan's In-Network cost sharing requirements. These cost-sharing amounts will be applied toward the In-

Network deductible and the Out-of-Pocket Limit in the same manner In-Network cost-share would be applied.

To speak to a clinical nurse regarding any health-related concern, any participant can call BlueKC at (877) 852-5422 (24 hours a day)

For up-to-date Prescription Drug information, you may visit Sav-Rx's website at www.savrx.com or you may call the Fund Office at (816) 777-2638 or visit the Fund website at www.bac15benefits.org.

For up-to-date Connection Dental Network provider information, you can visit www.gehasolutions.com, click on "Find a Dentist". You can also call toll-free at (800) 544-3014.

For prior authorization approval for genetic testing and medical necessity review of laboratory testing claims, you may contact Avalon Healthcare Solutions at (844) 277-5769 or visit their website at httpps://www.avalonhcs.com

Schedule of Benefits

The following Schedule of Benefits applies to the Plan's Actives and non-Medicare-eligible Retirees.

The Plan's benefits for Medicare-eligible Retirees and spouses are described in the Plan's group Medicare Advantage with Part D (MAPD) policy.

The following Coinsurance percentages apply to the network allowable amount for In-Network charges. All Coinsurance percentages apply to the Usual, Customary and Reasonable Charges for Out-of-Network charges. However, certain Out-of-Network Emergency Services, Out-of-Network services at an In-Network facility, and Air Ambulance Services may be subject to In-Network cost sharing requirements. See Section Twelve, subsection K for more information.

The calendar year deductible and out-of-pocket limits apply to all listed Benefits, unless otherwise stated. The Coinsurance percentages apply after the deductible is met, unless otherwise stated.

BENEFIT	**AMOUNT**
Major Medical Benefit	
Coinsurance *(Fund pays)*	
In-Network	90%
Out-of-Network	70%
Coinsurance *(Employee pays)*	
In-Network	10%
Out-of-Network	30%
Calendar Year Deductible	
In-Network	$ 300 per person
	$ 600 per family
Out-of-Network	$ 500 per person
	$1,000 per family
Emergency Room Copay	$100
Allowed charges over $100 subject to deductible and Coinsurance.	
Copay waived if person is admitted to the hospital.	
Maximum Annual Benefit	NONE
Maximum Out-of-Pocket Limit (Calendar Year)	$7,500 per family
Urgent Care Benefit	
Coinsurance *(Fund pays)*	
In-Network	90%
Out-of-Network	70%
Coinsurance *(Employee pays)*	
In-Network	10%
Out-of-Network	30%

Preventive Services/Routine Care Benefit

A broad range of Preventive Services have been approved by the Trustees. See Section Four, subsection J for more information on the Preventive Services benefits covered by the Plan.

Coinsurance *(Fund pays)*
- In-Network 100%
- Out-of-Network 70%

Coinsurance *(Employee pays)*
- In-Network 0%
- Out-of-Network 30%

Telehealth Benefit (BlueKC Virtual Care only*)

Benefit is not subject to Deductible or Co-Payment.

Coinsurance *(Fund pays)*
- In-Network or Out-of-Network 100%

Coinsurance *(Employee pays)*
- In Network or Out-of-Network 0%

*Telehealth obtained from a provider other than BlueKC Virtual Care will be subject to normal Coinsurance

Mental Health Benefit

Coinsurance *(Fund pays)*
- In-Network 90%
- Out-of-Network 70%

Coinsurance *(Employee pays)*
- In-Network 10%
- Out-of-Network 30%

Alcohol and Drug Treatment Benefit

Coinsurance *(Fund pays)*
- In-Network 90%
- Out-of-Network 70%

Coinsurance *(Employee pays)*
- In-Network 10%
- Out-of-Network 30%

Acupuncture Treatment Benefit

Employee Coinsurance does not apply to Out-of-Pocket Limits.

Coinsurance *(Fund pays)*
- In-Network 90%
- Out-of-Network 70%

Coinsurance *(Employee pays)*
- In-Network 10%
- Out-of-Network 30%

Maximum visits (per Calendar Year) ..... 30 per person

Chiropractic Expense Benefit

Employee Coinsurance does not apply to Out-of-Pocket Limits.

Coinsurance *(Fund pays)*

In-Network 90%

Out-of-Network 70%

Coinsurance *(Employee pays)*

In-Network 10%

Out-of-Network 30%

Maximum number of manipulations (per Calendar Year) ..... 30 per person

Hearing Aid Benefit

Coinsurance *(Fund pays)*

In-Network 90%

Out-of-Network 70%

Coinsurance *(Employee pays)*

In-Network 10%

Out-of-Network 30%

Maximum Benefit (Every Four Calendar Years) ..... $1,500 per person

Hospice Benefit

Coinsurance *(Fund pays)*

In-Network 90%

Out-of-Network 70%

Coinsurance *(Employee pays)*

In-Network 10%

Out-of-Network 30%

Maximum Counseling Visits per Bereavement ..... 5 (in 6 months period) per person

Maternity Benefit (Employee or Dependent Spouse Only)

Coinsurance *(Fund pays)*

In-Network 90%

Out-of-Network 70%

Coinsurance *(Employee pays)*

In-Network 10%

Out-of-Network 30%

Rehabilitative Therapy Benefit

Treating Physician must submit a Plan of Treatment to the Fund Office for approval prior to beginning therapy.

Coinsurance *(Fund pays)*

In-Network 90%

Out-of-Network 70%

Coinsurance *(Employee pays)*

In-Network 10%

Out-of-Network 30%

Surgery – Second Surgical Opinion

Coinsurance *(Fund pays)*
- In-Network or Out-of-Network..... 100%

Coinsurance *(Employee pays)*
- In-Network or Out-of-Network..... 0%

Bariatric Surgery Benefit (available only to Eligible Employee and Spouse)

The Coinsurance percentages apply only after the deductible has been met.

Coinsurance *(Fund pays)*
- In-Network (Blue Distinction Center Only) 90%

Coinsurance *(Employee pays)*
- In-etwork (Blue Distinction Center Only) 10%

Maximum Benefit (Lifetime).....$20,000 per person

Genetic Testing Benefit

Subject to deductible and prior authorization by Avalon Healthcare Solutions

Coinsurance *(Fund pays)*
- In-Network..... 90%
- Out-of-Network..... 70%

Coinsurance *(Employee pays)*
- In-Network..... 10%
- Out-of-Network..... 30%

Prescription Drug Benefit

Employee Co-Payment does not apply to Deductible or Out-of-Pocket Limits.

Retail Co-Payment *(Employee pays)*
- Level 1 – Generic, up to 34 days .....Lesser of $10 or 100% of cost of drug
- Level 1 – Generic, up to 90 days .....Lesser of $20 or 100% of cost of drug
- Level 2 – Preferred Brand Name ..... Greater of $25 or 25% of cost of drug
- Level 3 – Non-Preferred Brand Name ..... Greater of $40 or 25% of cost of drug
- Maximum days of Brand medication allowed..... 34 days per person per Co-Payment

Mail Order Co-Payment *(Employee pays)*
- Level 1 – Generic.....Lesser of $20 or 100% of cost of drug
- Level 2 – Preferred Brand Name ..... Greater of $50 or 20% of cost of drug
- Level 3 – Non-Preferred Brand Name ..... Greater of $80 or 20% of cost of drug
- Maximum days of medication allowed..... 90 days per person per Co-Payment

THE ANNUAL INDIVIDUAL AND FAMILY DEDUCTIBLES DO NOT APPLY TO THE PRESCRIPTION DRUG BENEFIT.

Dental Benefit

Coinsurance *(Fund pays)*
Covered Dental Charges 80%
Coinsurance *(Employee pays)*
Covered Dental Charges 20%
Maximum Benefit (Calendar Year) .....$1,750 per person
Additional Maximum Benefit (Calendar Year) .....$3,500 per person
Additional Benefit for pre-approved treatment related to life threatening illness.
Maximum Prophylactic Dental Exam (per Calendar Year).....2 per person
Orthodontia (Lifetime)
Covered Person through age 18 .....$1,000 per person
Dental Benefit limits do not apply to pediatric dental services (Eligible Dependents under age 19) as required by law.

Vision Benefit

Employee Coinsurance does not apply to Deductible or Out-of-Pocket Limits.

All Covered Persons Except for Eligible Dependents Under Age 19

Coinsurance *(Fund pays)*
Covered Vision 80%
Coinsurance *(Employee pays)*
Covered Vision 20%
Maximum Benefit (Calendar Year) .....$250 per person

Eligible Dependents Under Age 19

Coinsurance *(Fund pays)*
Covered Vision 100%
Coinsurance *(Employee pays)*
Covered Vision 0%
Coinsurance *(Fund pays)*
Covered Vision Hardware (lenses and frames) 100%
Coinsurance *(Employee pays)*
Covered Vision Hardware (lenses and frames) 0%
Maximum Hardware Benefit (Calendar Year) .....$250 per person*

*Or the covered charge on one (1) pair of eyeglasses with basic frames, or non-disposable contact lenses, which meet the minimum specifications to allow for necessary vision correction, whichever is greater per Calendar Year.

Death Benefit $10,000
Active Eligible Employee Only

Accidental Death and Dismemberment Benefit

Active Eligible Employee Only

Loss of:

Life	$10,000
Both Hands or Both Feet	$10,000
Entire Sight of Both Eyes	$10,000
One Hand **and** One Foot	$10,000
One Hand **or** One Foot **and** Entire Sight of One Eye	$10,000
One Hand **or** One Foot	$ 5,000
Entire Sight of One Eye	$ 5,000

Section Two – Eligibility

The following topics are discussed under this Section on Eligibility:

All Employees working for a contributing Employer or Employers within the various jurisdictions of the Plan for whom sufficient contributions have been paid shall be eligible to receive Benefits after meeting the following eligibility requirements.

A. Initial Eligibility

The following rules govern obtaining initial eligibility:

Standard Initial Eligibility Rule

An Employee who has worked at least 400 hours in a four consecutive month period will become initially eligible for Benefits on the first day of the third month following the month in which the 400 hours have been accumulated. The Employee remains eligible for Benefits until the end of the Benefit Period in which he/she initially becomes eligible.

Optional Immediate Initial Eligibility Rule

Notwithstanding the above initial eligibility rule, any new contributing employer will have a one-time opportunity to purchase immediate eligibility for all its currently covered (and newly bargained) employees. The cost to purchase this immediate eligibility for each such employee will be equal to the Fund's current COBRA Rate times the earlier of six months or the date the new Participant otherwise satisfies the initial eligibility rules as stated above.

If a new contributing employer chooses not to purchase immediate eligibility for its currently covered (and newly bargained) employees, the new Participants must meet the standard initial eligibility rule as stated above. In order to be eligible for optional immediate eligibility, the newly bargained employees must have employee coverage for the newly contributing employer and the Plan must be able to verify such

coverage. The employee's current coverage cannot be as a spouse on a different health plan.

B. Continuation of Eligibility

The following rule governs continuation of eligibility:

Once an Employee has satisfied the Initial Eligibility requirements, he/she will remain eligible for Benefits for the duration of that Benefit Period. Thereafter, he/she will remain eligible for Benefits as long as he/she is credited with at least 350 hours in a four month period or 700 hours in an eight month period as set forth in the table below.

Eligibility Periods for continued eligibility shall be divided into Work Periods and Benefit Periods as follows:

TABLE OF HOURS WORKED FOR BENEFIT PERIODS

Benefit Period	Work Period	Hours Required
April 1 thru July 31	Oct 1 – Jan 31 or June 1 – Jan 31	At least 350 hours or At least 700 hours
August 1 thru November 30	Feb 1 – May 31 or Oct 1 – May 31	At least 350 hours or At least 700 hours
December 1 thru March 31	June 1 – Sept 30 or Feb 1 – Sept 30	At least 350 hours or At least 700 hours

C. Eligibility Under the Family and Medical Leave Act

Pursuant to the requirements of the Family and Medical Leave Act of 1993 (FMLA), eligibility for Benefits shall be extended to Covered Employees and their Eligible Dependents if the Covered Employee has been granted unpaid leave by his/her Employer pursuant to the FMLA and if the Employer makes the required contributions to the Fund. Covered Employees and their Eligible Dependents shall be entitled to leave available under the FMLA for qualified family, medical and/or military-related reasons.

If a Covered Employee has been granted FMLA leave, the Employer shall notify the Fund Office at least 14 days before the onset of the leave, except in an emergency,

and then no later than seven days after the leave begins, to prevent a loss of eligibility. The Fund Office shall obtain a certificate of the Covered Employee's FMLA eligibility from the Employer. The Employer shall advise the Fund Office of the beginning date and ending date of the leave. The Employer shall notify the Fund Office of the date a Covered Employee advises the Employer that he/she does not intend to return to work.

The Employer will be required to pay the cost of continuing coverage in an amount equal to contributions for 25 hours of work per week for each week the Covered Employee is on FMLA leave. The Employer shall remit payment monthly, in arrears, upon billing by the Fund Office.

Eligibility will not be extended during the FMLA leave if the Employer does not make the required contributions to the Fund. The usual procedures of the Fund will be followed if the Employer does not make timely contributions and a loss of eligibility will result.

If you have any questions regarding the FMLA, please contact the Fund Office.

D. Eligibility for Active Disabled Employees

If an active eligible Employee becomes Totally Disabled from a Sickness or accidental bodily injury which prevents the Employee from engaging in any occupation or employment for wage or profit, the Employee will receive credit for 30 hours worked per week for a maximum of 13 weeks; provided that:

1. A claim form is submitted to the Fund Office that certifies the dates of disability and is signed and dated by a Physician,

2. A new form is submitted for each new period which certifies the dates of disability and is signed and dated by a Physician, and

3. Disabled Employees on Workers Compensation must submit Proof of Compensation and be unable to engage in any occupation or employment for wage or profit.

E. Effective Date of Dependent Coverage

Benefits for Eligible Dependents will become effective on the **latest** of the following dates:

1. The date the eligible Employee's Benefits become effective, or

2. The date the eligible Employee or Retiree acquires an Eligible Dependent, or

3. The date specified in a Qualified Medical Child Support Order.

If an eligible Employee or Retiree acquires a dependent while eligible for benefits, the Employee or Retiree should notify the Fund Office as soon as possible, but no later than 60 days. Provided such dependent meets the definition of Eligible Dependent as provided herein, the dependent shall automatically become covered.

If an Eligible Employee or Retiree fails to notify the Fund Office within the 60 day time limit, coverage for the dependent will begin on the first day of the month following receipt of the notice.

F. Exception to Dependent Coverage

Active Employees and Retirees with spouses who have coverage under an employer-sponsored health plan or government health program may waive coverage for the spouse under this Plan. For this waiver to become effective, the spouse must provide the Fund Office with written evidence of employer-sponsored health plan coverage or government health program coverage. The waiver will last until the spouse's employer-sponsored coverage or government health program coverage terminates. The spouse must notify the Fund Office when the spouse's employer-sponsored coverage terminates. The spouse will then become covered under the Plan again, **provided the Fund Office is notified of the termination of the employer-sponsored coverage within 31 days of the termination. A spouse for whom the Employee o Retiree waives spousal coverage under the Plan due to the spouse having coverage under a government health program is not eligible to again be covered under the Plan until coverage under the government health program is terminated.**

An Employee or Retiree may only waive coverage for his/her spouse one time.

In addition, an Eligible Dependent child of a Retiree may waive coverage from the Plan. For this waiver to become effective, the Retiree must submit a written request to waive the child's coverage to the Fund Office and submit documentation of enrollment in another employer-provided health care program. Such child would be allowed to re-enroll in the Plan upon the termination of the employer-provided health care program. The child's coverage would again be effective the first day of the month following the date the Fund Office receives completed re-enrollment paperwork for the child.

G. Eligibility for Retirees and Eligible Dependents

The following rules govern eligibility for Retirees and their Eligible Dependents:

1. Retirees under age 55, eligible for Medicare and with at least 17 Years of Service in the past 20 years

   An eligible Employee who: (a) is under age 55; (b) is eligible for Medicare; (c) has at least 17 Years of Service in the past 20 years under the BAC Local Union 15 Pension Plan, or the OCI Pension Fund, and (d) has exhausted extended coverage under COBRA, is eligible to continue Benefits provided under this Plan by making the required self-payments.

2. Retirees between ages 55 and 64

An eligible Employee who: (a) is receiving benefit payment under the BAC Local Union 15 Pension Fund or the OCI Pension Fund; (b) is between ages 55 and 64; (c) has been eligible under the BAC Local Union 15 Welfare Fund for at least 12 consecutive months prior to retirement; (d) loses eligibility as an active Eligible Employee under the BAC Local Union 15 Welfare Fund; and (e) has at least 17 Years of Service in the last 20 plan years under the BAC Local Union 15 Pension Planor the OCI Pension Fund, will become eligible for continuing Benefits provided under this Plan by making the required self-payments.

In the event of the merger of another health plan with this Plan, or the transfer of a group of participants from another health plan to this Plan, pension credits earned by such participants under the other health plan's related pension plan will count towards the fulfillment of the 17 Years of Service in the past 20 years requirement in the preceding paragraph. Evidence of these pension credits will be required. No other pension credits besides the aforementioned (such as those earned by an individual transferring to this Plan) may be used to fulfill the 17 Years of Service in the last 20 plan years requirement.

3. Retirees age 65 and Over

An eligible Employee who:

(a)

(i) is receiving benefits from BAC Local Union 15 Pension Fund or the OCI Pension Fund,

(ii) who is age 65 or older; and

(iii) has been eligible under the Plan during the complete 12 months prior to retirement will remain eligible for continuing Benefits provided under this Plan by making the required self-payments; or

(b)

(i) loses eligibility as an active Eligible Employee under the BAC Local Union 15 Welfare Fund; and

(ii) has at least 17 Years of Service in the past 20 Plan years under the BAC Local Union 15 Pension Plan or the OCI Pension Fund

will become eligible for continuing Benefits provided under this Plan by making the required self-payments.

The Benefits available to Retirees eligible for Medicare will be paid through the Plan's group Medicare Advantage with Part D (MAPD) program.

In the event of the merger of another health plan with this Plan, or the transfer of a group of participants from another health plan to this Plan, pension credits earned by such participants under the other health plan's related pension plan will count towards the fulfillment of the 17 Years of Service in the prior 20 plan year requirement in the preceding paragraph. Evidence of these pension credits will be required. No other pension credits besides the aforementioned (such as those earned by an individual transferring to this Plan) may be used to fulfill the 17 Years of Service in the past 20 Plan years requirement.

H. Termination of Eligibility for Eligible Employees

1. Eligibility will terminate on:

   a. The first day the Employee works for an Employer whose contractual obligation to contribute to the Fund has terminated (termination does not occur if the Employer is negotiating for a new contract and making contributions to the Fund); or

   b. The first day the Employee works in employment in the jurisdiction of the Fund for an employer that does not have a contractual obligation to contribute to the Fund , in the jurisdiction in which the Fund has a reciprocal agreement in place.

   If within 30 days of receiving a termination notice under Paragraphs 1.a. or 1.b. of this Subsection H., an Employee provides acceptable proof, as determined by the Trustees, that he is no longer working for an Employer who does not have a contractual obligation to contribute to the Fund, coverage will be reinstated.

2. A review of the hours contributed on behalf of an Employee shall be made prior to April 1, August 1 and December 1 of each year. Eligibility will terminate on any of these dates if:

   a. The Employee fails to satisfy the requirements set forth under the Continuation of Eligibility as explained in Section Two B.,

   b. The Employee fails to elect Continuation of Coverage (COBRA),

   c. The Employee fails to make a required self-payment, or

   d. The Employee dies.

I. Reestablishment of Eligibility

If, after becoming eligible, a Participant loses his/her eligibility and has been ineligible for less than 24 months and the Participant has been available for work under the jurisdiction of the Fund, the Participant may re-establish his/her eligibility after at least 350 hours of Employer contributions have been received on the Participant's behalf in a four-month Work Period. A Participant will become eligible for coverage on the first day of the third month following the month in which the 350

hours have been accumulated and will remain eligible for benefits until the end of the Benefit Period in which he/she reestablishes eligibility.

If, after becoming eligible, a Participant loses his/her eligibility and has been ineligible for more than 24 months, the Participant will be considered a new Employee and must satisfy the Initial Eligibility Rules (400 hours of Employer contributions in a consecutive four-month period).

J. Termination of Eligibility for Dependents

The eligibility for Benefits for Eligible Dependents will terminate upon the occurrence of the first of the following:

1. The individual fails to satisfy the definition of Eligible Dependent as defined in Section Fifteen J.,

2. The individual fails to elect Continuation of Coverage (COBRA),

3. The individual fails to make a required self-payment.

4. In the case of an eligible spouse of a deceased Retiree, the spouse remarries, or

5. In the case of an eligible spouse of a deceased Retiree, the spouse becomes eligible for Medicare.

Upon the death of an eligible Employee, the eligibility of that Employee's Eligible Dependents shall be extended to the end of the eligibility period based upon the deceased eligible Employee's accrued hours. Thereafter, the eligibility for Benefits will be governed by the Continuation of Coverage (COBRA) provisions and the following surviving spouse coverage rules.

Surviving Spouse of an Active Participant

Upon the death of an active Participant with at least 17 years of service at the time of death, the active Participant's covered spouse will be allowed to continue coverage under the Plan by self-paying the prevailing COBRA contribution rate until remarriage. Once the covered spouse is eligible for Medicare, rates will be adjusted to allow the covered spouse to continue coverage by self-paying the prevailing Medicare-Primary Retiree self-payment rate until he or she remarries.

Surviving Spouse (Not Eligible for Medicare) of a Retiree

Upon the death of an eligible Retiree, the eligible spouse who is not eligible for Medicare shall be allowed to continue coverage for the later of 36 months or when he or she remarries by self-paying the lesser of:

- the prevailing Retiree contribution self-payment rate; or

- the prevailing COBRA rate.

Once the eligible spouse is eligible for Medicare, the Plan's self-payment rates will be adjusted to allow the covered spouse to continue coverage under the Plan by self-

paying the prevailing Medicare-primary Retiree self-payment rate until he or she remarries.

Surviving Spouse (Eligible for Medicare) of a Retiree
Upon the death of an eligible Retiree, the eligible spouse who is eligible for Medicare shall be allowed to continue coverage by self-paying the prevailing Medicare-primary Retiree self-payment rate until he or she remarries.

K. Short Hour Self Pay

Participants may make *Short Hour Self Payments* in the amount that is the difference between the required number of hours (in either the four month Work Period or eight month Work Period) and the actual number of hours that you worked in the same Work Period multiplied by the current contribution rate. **The *Short Hour Self Pay* option may be utilized for any Benefit Period with 0 hours in the most recent Work Period provided that at least 350 hours were reported in the preceding Work Period.** The Short Hour Self Pay option is limited to one (1) Benefit Period in a consecutive 12 month period. Please note, COBRA will still be available if coverage is lost in a subsequent period because of failure to meet the continuation of eligibility rules in Section Two B, after use of the Short Hour Self Pay option.

Participants who return to work after having been disabled and who have received up to the maximum of 120 hours of credit due to disability, may make short-hour self-payment if coverage is subsequently lost. Participants shall pay the difference between the credited disability hours and the actual hours worked.

Example #1

Benefit Period	Required Hours in Work Period	Actual Hours Worked in Work Period	Difference in Required Hours and Actual Hours
12/1/21 – 3/31/22	350 Hours from 6/1/21 – 9/30/21	100 Hours	-250 Hours
	Or		
	700 Hours from 2/1/21 – 9/30/21	500 Hours	-200 Hours

In **Example #1**, the *Short Hour Self Payment* would be based on the requirement of 700 hours in the eight month Work Period because that creates the lower *Short Hour Self Payment*. The amount of the *Short Hour Self Payment* would be 200 hours multiplied by the current contribution rate.

Example #2

Benefit Period	Required Hours in Work Period	Actual Hours Worked in Work Period	Difference in Required Hours and Actual Hours
12/1/21 – 3/31/22	350 Hours from 6/1/21 – 9/30/21 Or 700 Hours from 2/1/21 – 9/30/21	250 Hours 400 Hours	-100 Hours -300 Hours

In **Example #2**, the *Short Hour Self Payment* would be based on the requirement of 350 hours in the four month Work Period because that creates the lower *Short Hour Self Payment*. The amount of the *Short Hour Self Payment* would be 100 hours multiplied by the current contribution rate.

Example #3

Benefit Period	Required Hours in Work Period	Actual Hours Worked in Work Period	Difference in Required Hours and Actual Hours
12/1/21 – 3/31/22	350 Hours from 6/1/21 – 9/30/21	0 Hours	-350 Hours
	And 350 Hours from 2/1/21 – 5/31/21	600 Hours	+250 Hours
	Total Hours Needed to Meet Eligibility		100 Hours

In **Example #3**, the Participant may utilize the *Short Hour Self Payment* even though no hours were reported in the most current Work Period because over 350 hours were reported for the preceding Work Period. In this example, even though no hours were reported in the current Work Period, the amount of the *Short Hour Self Payment* would be 100 hours multiplied by the current contribution rate due to the number of hours reported in the previous Work Period.

L. Continuation of Coverage (COBRA)

Federal law requires that sponsors of group health plans such as the BAC Local Union 15 Welfare Fund offer Covered Employees and their families a temporary extension of their health care coverage under the Plan, (called "COBRA Continuation Coverage") in exchange for self-contribution payments to the Plan. The right to an extension of health care coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you and to other members of your family (the Covered Employee's spouse and dependents under the terms of the Plan) who are covered by the Plan when you would otherwise lose your group health coverage, referred to as "qualified beneficiaries."

What is COBRA Continuation Coverage?

If a Covered Employee or Eligible Dependent loses health care coverage due to a reduction in hours, termination of employment, or certain other events (called qualifying events), the Covered Employee and the Eligible Dependent(s) have the right to elect to continue health care coverage by making premium payments to the Plan.

1. COBRA Continuation Coverage will be offered to a Covered Employee if coverage under the plan ends for the following reasons:

    a. The Covered Employee's hours of employment are reduced, or

    b. The Covered Employee is terminated from employment for any reason other than the Covered Employee's gross misconduct.

2. COBRA Continuation Coverage will be offered to the spouse of a Covered Employee if coverage under the Plan ends for the following reasons:

    a. The Covered Employee's hours of employment are reduced;

    b. The Covered Employee is terminated from employment for any reason other than the Covered Employee's gross misconduct;

    c. The Covered Employee dies;

    d. The Covered Employee becomes enrolled in Medicare; or

    e. The Covered Employee and spouse become legally separated or divorce.

3. COBRA Continuation Coverage will be offered to an Eligible Dependent child if coverage under the Plan ends for the following reasons:

    a. The Covered Employee's hours of employment are reduced;

    b. The Covered Employee is terminated from employment for any reason other than the Covered Employee's gross misconduct;

c. The Covered Employee dies;

d. The Covered Employee becomes enrolled in Medicare;

e. The Covered Employee and spouse become legally separated or divorced; or

f. The dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

How long will COBRA Continuation Coverage last?

1. 18 months
   If the Covered Employee and/or the Eligible Dependent lose coverage due to a reduction in the Covered Employee's hours or due to the end of the Covered Employee's employment, COBRA Continuation Coverage is available for a maximum of up to 18 months.

2. 29 months
   If the Covered Employee and/or Eligible Dependent is disabled (as determined under Titles II or XVI of the Social Security Act) at the time his or her coverage would otherwise terminate because of a reduction of hours or termination of employment, or who becomes disabled during the initial 60 days of COBRA Continuation Coverage, and the Fund Office has been notified in writing of the disability prior to the expiration of the initial 18 month period of COBRA Continuation Coverage, the Covered Employee and/or Eligible Dependent can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months of COBRA Continuation Coverage. However, if a Covered Employee (not an Eligible Dependent) has made self-payments for 29 months, and the Social Security Disability application is pending on appeal, such Covered Employee may continue to make COBRA payments until final resolution of the appeal. The Fund shall request such documentation as is necessary to substantiate the status of the appeal.

3. 36 months
   COBRA Continuation Coverage lasts up to a maximum of 36 months if the Covered Employee's spouse or Eligible Dependent child's health care coverage ends due to:

   a. The Covered Employee and spouse become legally separated or divorce;

   b. The Covered Employee becomes enrolled in Medicare;

   c. The Covered Employee dies; or

   d. A dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

4. Second Qualifying Event
   COBRA Continuation Coverage may also be extended for up to 36 months if your family experiences another event, called a "qualifying event" while receiving COBRA Continuation Coverage. If, while receiving COBRA Continuation Coverage, one of the following events occur, an Eligible Dependent is eligible for an extension of COBRA Continuation Coverage up to a maximum period of 36 months:

   a. The Covered Employee and spouse become legally separated or divorce;

   b. The Covered Employee becomes enrolled in Medicare;

   c. The Covered Employee dies; or

   d. A dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

Keeping the Fund Office Informed of Changes

In order to protect your family's rights, the Fund Office should be informed of any changes concerning your family. The Covered Employee and any Eligible Dependent has the responsibility to notify the Fund Office within 60 days of a divorce, legal separation or a dependent child's loss of dependent status. **Failure to keep the Fund Office informed of these changes may affect your rights to COBRA Continuation Coverage.** While it is the responsibility of the Employer to notify the Fund Office of a reduction in the Covered Employee's hours, termination of employment, enrollment in Medicare, or Covered Employee's death, the Covered Employee or Eligible Dependent should also notify the Fund Office of the event in order to prevent a delay in the start of the COBRA Continuation Coverage.

In the event the Covered Employee or Eligible Dependent becomes disabled during the initial 60 day COBRA continuation period, it is the responsibility of the Covered Employee or Eligible Dependent to notify the Fund Office of the determination of disability. **Failure to notify the Fund Office of a disability determination may affect your right to extend the COBRA Continuation Coverage period due to disability.**

Electing to Continue Coverage

When the Fund Office is notified that coverage will end due to a qualifying event, the Covered Employee and Eligible Dependent(s) will be notified of their right to choose the Continuation Coverage. The Fund Office will send you and your family a COBRA Election Notice containing information on how to continue your health care coverage and the applicable COBRA premiums. The Covered Employee and Eligible Dependent(s) will then have the **later** of **60** days from the date on which coverage under the Plan would otherwise terminate, or **60** days from receipt of the Election Notice to elect the Continuation Coverage. If the Covered Employee or Eligible Dependent(s) does not elect the Continuation Coverage within the 60 day election period, coverage under the Plan will end as of the date the coverage would have otherwise ended without regard to the 60 day election period.

Each Eligible Dependent has an independent right to elect COBRA Continuation Coverage. Parents may make the election on behalf of their Eligible Dependents.

If a Covered Employee or Eligible Dependent has a newborn child, or adopts a child, or has a child placed with him or her for adoption during the COBRA continuation period, this child will be eligible for COBRA Continuation Coverage. The Fund Office must be notified as soon as possible after the birth or placement in order for the child to be added to the COBRA Continuation Coverage.

The COBRA Continuation Coverage offered by the Fund is the same coverage provided under the Plan at the time of termination except that Accidental Death and Dismemberment Benefits are not available.

Payments

The amount of the COBRA Continuation Coverage premiums shall be determined by the Trustees. For the first Benefit Period payments for COBRA Continuation Coverage, the Covered Employee will be given credit for the actual hours contributed on the Covered Employee's behalf during the four month Work Period covered under the Eligibility Periods as set forth in Section Two. After the first Benefit Period, all subsequent payments shall be determined by the Trustees but no deduction for hours shall be credited after the first Benefit Period.

After the Covered Employee or Eligible Dependent elects to receive COBRA Continuation Coverage, the first premium must be made within 45 days of the election. Failure to make the required premium payments within the initial 45 day period will result in the loss of the COBRA Continuation Coverage.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will end if any of the following occur:

1. A required self-payment premium for COBRA Continuation Coverage is not made on or before each monthly due date;

2. The Covered Employee or Eligible Dependent becomes covered under another group health plan;

3. The Covered Employee or Eligible Dependent becomes entitled to Medicare;

4. The Fund no longer provides group health care coverage; or

5. The maximum number of months of COBRA Continuation Coverage has been reached, as explained above.

M. Service in the Armed Forces

Each Covered Employee, whose eligibility terminates because of entrance into active duty with the Armed Forces of the United States and who returns to active work with a contributing Employer within the time periods described in N.4 below shall become eligible under this Plan on the date of commencement of such active work, subject to USERRA.

If a Covered Employee's eligibility terminates because of entry into active duty with the Armed Forces of the United States, any Benefits hereunder with respect to any Eligible Dependent of such Covered Employee on the date of such termination shall be continued in force while such dependent continues to be an Eligible Dependent but not beyond the end of the Benefit Period, subject to USERRA.

N. Uniformed Services Employment and Reemployment Rights Act (USERRA)

The following rules govern your rights under USERRA:

1. Effective Date

   The Uniformed Services Employment and Reemployment Rights Act of 1994 protects the eligibility of an Employee and offers continuation coverage to the Employee and the Employee's Eligible Dependents after the Employee enters into Military Service.

2. Return to Work Coverage Guaranteed

   USERRA requires an Employer, or a multiemployer health care plan, to protect any health care Benefits an Employee has already earned up to the time an Employee enters Military Service if the Employee re-applies for work within prescribed time periods after an honorable discharge.

   The Employee's eligibility status must be "frozen" when the Employee enters Military Service and must be fully restored when the Employee re-applies for work with the same Employer or, in the case of a multiemployer plan, with any Employer who is signatory to the Collective Bargaining Agreement.

   When an Employee returns from Military Service, no exclusion or waiting period may be imposed in connection with the restoration of health care coverage that would not otherwise apply if the Employee had not entered Military Service.

3. Continuation of Coverage While in the Military

   USERRA requires a group health care plan to offer identical health care coverage **up to 24 months** to persons who have coverage in connection with their employment but who are absent from such employment due to Military Service.

THE EMPLOYEE MUST NOTIFY THE FUND OFFICE IMMEDIATELY WHEN THE EMPLOYEE KNOWS HE/SHE IS ENTERING MILITARY SERVICE.

If notification of the Fund Office is delayed for several months, the extension of coverage for a maximum of 24 months still begins with the initial date of entry into Military Service and a retroactive payment to that date may be charged. The Employee has an obligation to notify the Fund Office, as soon as the Employee knows he/she is entering Military Service **if the Employee wishes to take advantage of continued coverage. Failure to notify the Fund Office may be taken as an indication that the Employee does not wish to purchase coverage for the Employee or the Employee's Eligible Dependents.**

4. Re-employment Requirements when Returning from Military Service

The application period for re-employment is based on a time schedule keyed to the length of time spent in Military Service.

Military Service Less than 31 Days

For Military Service of less than 31 days, a Service member must apply for re-employment with a signatory Employer at the beginning of the next regular scheduled work period on the first day after release from Service with an honorable discharge, taking into account safe transportation plus an eight hour rest period.

Military Service More than 31 Days but Less than 181 Days

For Military Service of 31 days or more but less than 181 days, an application for re-employment must be filed within 14 calendar days (not work days) after the Service member's release from the Service with an honorable discharge.

Military Service Over 181 Days

For Military Service over 181 days, an application for re-employment must be submitted within 90 calendar days (not work days) after an honorable discharge.

5. Definitions

"Health Coverage" means Hospital, surgical, medical, dental or vision coverage provided under the Plan. Health Coverage is subject to change as a result of Plan modification.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to USERRA and any interpretive regulations or rulings).

"Covered Person" means a Covered Employee or Eligible Dependent as defined in Section Fifteen of this Plan.

"Service in the Uniformed Services" or "Military Service" means the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment

for the purpose of an examination to determine the fitness of the person to perform any such duty.

"Uniformed Services" means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

6. Continuation of Group Health Coverage

If Health Coverage ends because of Service in the Uniformed Services, a Covered Person may elect to continue such Health Coverage, if required by USERRA, until the **earlier** of:

a. The end of the period during which the Covered Employee is eligible to apply for reemployment in accordance with USERRA, or

b. 24 consecutive months after coverage ended.

To continue coverage, a Covered Person must pay the required premium, unless Service in the Uniformed Service is for fewer than 31 days. The Fund Office shall inform the Covered Person of the procedures to pay premiums. The USERRA premium shall be equal to the COBRA premium.

A Covered Person's continued Health Coverage under USERRA will end at midnight on the **earliest** of:

a. The day the Plan is terminated,

b. The day a premium is due and unpaid,

c. The day the Covered Person again becomes covered under the Plan, or

d. The day the Health Coverage has been continued for the period of time provided above (or any longer period provided in the Plan).

7. Conflict Resolution

In the event of a conflict between this provision and USERRA, the provisions of USERRA shall apply.

Section Three – Life Events at a Glance

There are several significant events that may occur while you are covered under the Plan. Please contact the Fund office, in writing, if any of the following occurs:

- **YOUR ADDRESS OR TELEPHONE NUMBER CHANGES.**
- **YOU MARRY, DIVORCE OR OBTAIN A LEGAL SEPARATION FROM YOUR SPOUSE.** You must also submit the appropriate legal documents (for example: marriage certificate, divorce decree, custody agreement).
- **YOU CHANGE YOUR BENEFICIARY.**
- **YOUR DEPENDENT CHILD NO LONGER QUALIFIES AS AN ELIGIBLE DEPENDENT UNDER THE TERMS OF THE PLAN.**
- **YOU BECOME A PARENT.** You must also submit the child's state-certified birth certificate, decree of adoption or placement for adoption, a Qualified Medical Child Support Order or other legal documentation.
- **YOU GO INTO OR RETURN FROM MILITARY SERVICE.**
- **YOU BEGIN RECEIVING WORKERS' COMPENSATION BENEFITS.**
- **YOU BECOME ELIGIBLE FOR MEDICARE.**
- **YOU RETIRE.**

You may contact the Fund Office at:

BAC Local Union 15 Welfare Fund
PO Box 909500
Kansas City, MO 64190-9500
(816) 777-2668 or (833) 479-9428

http://www.bac15benefits.org/

Section Four – Medical Benefits

The Benefits listed in the table below are described in this Section. This table is only intended to give you a brief summary of Benefits available. Please refer to the description of Benefits immediately after the table to fully understand the benefit and any specific maximums or limitations.

Certain Out-of-Network Emergency Services, Out-of-Network services at an In-Network facility, and Air Ambulance Services may be subject to In-Network cost sharing requirements. See Section Twelve, subsection K for more information.

NOT ALL BENEFITS ARE AVAILABLE TO ALL COVERED ACTIVES AND NON-MEDICARE RETIREES. THE PLAN'S BENEFITS FOR MEDICARE-AGED RETIREES ARE DESCRIBED IN THE PLAN'S GROUP MEDICARE ADVANTAGE WITH PART D (MAPD) POLICY. PLEASE CONSULT THE APPLICABLE SCHEDULE OF BENEFITS TO DETERMINE IF YOU OR YOUR DEPENDENTS ARE ELIGIBLE FOR ANY PARTICULAR BENEFIT.

Description of Covered Benefit	**Fund Coinsurance Amount** Coinsurance amounts are based on a percent of UCR Charge		**Does your Coinsurance amount help meet your Out-of-Pocket Limit?**	**Do you need to meet your calendar year Deductible before receiving Benefit?**
	In-Network	**Out-of-Network**		
Major Medical Benefit	90%	70%	Yes	Yes
Telehealth Benefit (BlueKC Virtual Care)	100%	n/a	n/a	n/a
Urgent Care Benefit *See Benefit Description for Specific Limitations*	90%	70%	Yes	Yes
Rehabilitative Therapy Benefit *See Benefit Description for Specific Limitations*	90%	70%	Yes	Yes

ANY PARTICIPANT CAN CALL TOLL-FREE (877) 852-5422 AND SPEAK TO A CLINICAL NURSE FOR ANY HEALTHCARE CONCERN 24 HOURS A DAY / 7 DAYS A WEEK / 365 DAY A YEAR.

Description of Covered Benefit	Fund Coinsurance Amount (Coinsurance amounts are based on a percent of UCR Charge) In-Network	Out-of-Network	Does your Coinsurance amount help meet your Out-of-Pocket Limit?	Do you need to meet your calendar year Deductible before receiving Benefit?
Surgery – Second Surgical Opinion	90%	70%	Yes	Yes
Bariatric Surgery Benefit *See Benefit Description for Specific Limitations*	90%	n/a	Yes	Yes
Rehabilitative Therapy Benefit *See Benefit Description for Specific Limitations*	90%	70%	Yes	Yes
Preventive Services/Routine Care Benefit *See Benefit Description for Specific Limitations*	100%	70%	Yes	No
Mental Health Benefit *See Benefit Description for Specific Limitations*	90%	70%	Yes	Yes
Alcohol and Drug Treatment Benefit *See Benefit Description for Specific Limitations*	90%	70%	Yes	Yes
Acupuncture Treatment Benefit *See Benefit Description for Specific Limitations*	90%	70%	No	Yes
Chiropractic Expense Benefit *See Benefit Description for Specific Limitations*	90%	70%	No	Yes
Hearing Aid Benefit *See Benefit Description for Specific Limitations*	90%	70%	Yes	Yes
Hospice Benefit *See Benefit Description for Specific Limitations*	90%	70%	Yes	Yes
Maternity Benefit *(Employee or Dependent Spouse Only)*	90%	70%	Yes	Yes

A. Acupuncture Treatment Benefit

Benefits for acupuncture treatment will be paid according to the Schedule of Benefits if the treatment is performed by a professional who is licensed and certified in acupuncture.

Benefit Limitations

The Benefit will be limited to a maximum of 30 visits per Covered Person per Calendar Year.

B. Alcohol and Drug Treatment Benefit

Benefits for treatment of alcoholism, chemical dependency or substance use are payable according to the Schedule of Benefits for the Usual, Customary and Reasonable Charges for medical expenses for treatment, if such care and services are ordered and prescribed by a Legally Qualified Substance Use Professional. For the purposes of this benefit only, a "Legally Qualified Substance Use Professional" includes: psychiatrists, psychologists, certified mental health or substance use counselors, or a social worker who has a master's degree and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of alcoholism and substance abuse under the laws of the state or jurisdiction where the services are rendered and who acts within the scope of his or her license. Benefits for treatment of Alcohol and Drug Treatment Benefit are payable under the Major Medical Benefit provision subject to the same terms, conditions and limitations governing the individual benefits for any other sickness or injury under the Plan.

Allowed charges are:

1. Charges by a Hospital for room and board charges (semi-private room only),

2. Charges for treatments by a Legally Qualified Substance Use Professional,

3. Charges for individual therapy by a Legally Qualified Substance Use Professional,

4. Administration of drugs or medicine if prescribed by a Legally Qualified Substance Use Professional legally authorized and licensed to prescribe drugs or medicine,

5. Out-Patient charges for both Hospital and office visits, and

6. Nutritional counseling.

Benefits for treatment of alcohol or drug use are **NOT** payable for:

1. Service or treatment rendered by anyone other than a Legally Qualified Substance Use Professional, or

2. Any charges related to a period of confinement or frequency of treatment which is considered custodial or not reasonable for the diagnosed conditions(s).

C. Bariatric Surgery Benefit

When an Eligible Employee or Spouse requires bariatric surgery, Benefits will be paid according to the Schedule of Benefits for Usual, Customary and Reasonable Charges after the deductible. This benefit must be Medically Necessary and requires pre-authorization, and is only available In-Network through a Blue Distinction Center. Nutritional counseling services, skin revision surgery, bariatric surgery reversals and expenses related to complications from Medically Necessary determined procedures are allowed up to the lifetime maximum stated in the Schedule of Benefits.

D. Chiropractic Expense Benefit

Benefits for Chiropractic Expense Benefit will be paid according to the Schedule of Benefits if the treatment is performed by a licensed chiropractor.

Chiropractic Expense Benefits are **NOT** payable for:

1. Any treatment by a chiropractor other than manual manipulation to correct subluxation, including (but not limited to) allergy therapy, diet or hair analysis,

2. Any diagnostic x-ray or laboratory procedure other than an x-ray to diagnose subluxation, including (but not limited to) urinalysis or blood chemistry,

3. Nutritional or food supplements and/or vitamins which may be legally obtained without a Physician's prescription,

4. Pillows, supports or similar devices,

5. More than one treatment per day, or

6. Booklets.

Benefit Limitations

Visits are limited to 30 manipulations per Covered Person per Calendar Year. Benefits for or related to treatment by a chiropractor are subject to the same terms, conditions and limitations governing individual Benefits for any other Sickness or injury.

E. Hearing Aid Benefit

Benefits, on behalf of a Covered Person, for Covered Services for hearing aids, services or supplies will be paid according to the Schedule of Benefits, subject to a $1,500 maximum each four calendar years.

F. Hospice Benefit

Benefits, on behalf of a Covered Person, for Covered Services for Hospice Care will be paid according to the Schedule of Benefits.

Hospice Benefits will only be paid if the patient's attending Physician certifies, in writing, that the patient is terminally ill and that the patient is expected to die within six months or less.

Allowed charges are:

1. Room and board for confinement in a Hospice,
2. Services and supplies furnished by the Hospice while the patient is confined therein,
3. Part-time nursing care by or under the supervision of a Registered Nurse (RN),
4. Home Health Aide services,
5. Nutrition services,
6. Special meals,
7. Counseling services by a licensed social worker or a licensed pastoral counselor, and
8. Bereavement counseling by a licensed social worker or a licensed pastoral counselor for a patient's immediate family but limited to five visits during a six month period following the patient's death.

Hospice Benefits are **NOT** payable for:

1. Custodial Care or Services (i.e. room and board or other institutional or nursing services which are provided to or for a Covered Person due to the Covered Person's age, mental or physical condition) mainly to aid the person in daily living, or
2. Medical services to maintain the person's present state of health and which cannot reasonably be expected to improve the Covered Person's medical condition.

Benefit Limitations

Maximum Visits per Bereavement ..... 5 (in 6 months period) per person

G. Major Medical Benefit

Medical expenses included under the Major Medical Benefit will be payable based on the UCR Charge for Medically Necessary care and services that are ordered and prescribed by a Physician according to the Schedule of Benefits.

CHRONIC CONDITION MANAGEMENT AND LIFESTYLE COACHING AVAILABLE FOR ALL COVERED PERSONS DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS:

Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Depression, Diabetes, Heart Failure, Hypertension, Metabolic Syndrome and Cancer.

Deductible Amount

The Deductible Amount is $300 per person or $600 per family for Expenses Incurred In-Network per calendar year; or $500 per person or $1,000 per family for Expenses Incurred Out-of-Network per calendar year. The Deductible Amount must be paid by the Employee before any Benefits under the base Plan of Benefits will be paid and will be applied only once per calendar year. The Deductible Amount does apply towards the annual Maximum Out-of-Pocket Limit.

SMART HEALTHCARE CONSUMER TIP:

Use the Hospital Emergency Room for Real Emergencies

If you need non-emergency same day care outside the office hours of your Physician, consider utilizing the Blue KC Virtual Care Telehealth, Virtual PPO doctor visit benefits, or an urgent care facility.

Allowed Charges

Medical expenses included under the Major Medical Benefit will be payable for the following Medically Necessary care and services which are ordered and prescribed by a Physician:

1. Hospital for room and board charges (semi-private room only).

2. Hospital emergency room charges. Emergency room Copay will be waived if the Covered Person is admitted to the Hospital.

3. Private duty service of a registered graduate/licensed practical nurse, except when the nurse is related to the Covered Person.

4. X-ray and laboratory services for diagnostic purposes.

5. Anesthesia.

6. Administration and cost of blood or blood plasma.

7. Prescription drugs and medicine if prescribed by a Physician and dispensed by a licensed pharmacist for approved label purposes.

8. Surgery performed on an Out-Patient basis.

9. Surgical Procedures performed on a Covered Person for treatment of a non-occupational Sickness or accidental bodily injury. Charges made by an assistant surgeon will be considered under the Major Medical Benefit, provided such assistance is considered Medically Necessary.

   Definitions

   "Surgical Procedure" means certain invasive procedures, as well as the reduction of fractures or dislocations, in addition to recognized cutting procedures. Surgical Procedures may be performed in a Hospital, Physician's office or elsewhere.

   "Surgical Benefits" include charges for necessary and related pre-operative and post-operative care (and any anesthetic customarily administered by the surgeon) as part of the Surgical Procedure.

10. Services of a licensed physiotherapist.

11. Durable Medical Equipment that meets each of the following criteria:

    a. Is certified, in writing, by the prescribing Physician as necessary in the treatment, habilitation or rehabilitation of a handicapped person,

    b. Is primarily and customarily used to serve a medical or rehabilitative purpose rather than primarily for transportation, comfort or convenience. The fact that the equipment or device is also useful for transportation, comfort or convenience will NOT serve as a disqualifying factor,

    c. Is not beyond the appropriate level of performance and quality required under the circumstances (i.e., non-luxury, non-deluxe),

    d. Would NOT be necessary in the absence of an Sickness or physical or mental disability, and

    e. Is appropriate for and intended for use in the home.

    Examples of Durable Medical Equipment include equipment to assist mobility, such as a standard wheelchair, a standard Hospital type bed, oxygen concentrator units and the rental of equipment to administer oxygen, delivery pumps for tube feedings, braces that stabilize an injured body part, or mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions. Nondurable supplies (i.e. tubing, connectors and masks) are a Covered Expense when used with Covered Durable Medical Equipment. This Plan does not cover maintenance fees (i.e. batteries or warranties) related to Covered Durable Medical

Equipment. Requests for Durable Medical Equipment must be accompanied by a Physician's statement describing the Medical Necessity and length of use. The cost of these items will be limited to an amount determined by the Trustees. Rental of Durable Medical Equipment is covered up to the purchase price. **You should contact the Fund Office before purchasing or renting any of these items if you wish to know the cost that will be covered.**

12. Initial placement of contact lenses required due to cataract surgery.

13. Services for cosmetic and reconstructive surgery for injuries received: (a) as a result of a Surgical Procedure for which Benefits were paid under the Plan, or (b) for reconstruction of a breast on which a mastectomy has been performed, for surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance, or for coverage for prostheses and physical complications of all states of mastectomy (including lymphedemas) in a manner determined in consultation with the attending Physician and the patient.

14. Human organ and tissue transplants (Contact the Fund Office for coverage details).

15. Prosthetic appliances ($25,000 lifetime maximum).

H. Maternity Benefit

Maternity Benefits include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

MATERNITY BENEFITS ARE PAYABLE UNDER THE MAJOR MEDICAL BENEFIT PROVISION ONLY AND ARE SUBJECT TO THE SAME TERMS, CONDITIONS AND LIMITATIONS GOVERNING THE INDIVIDUAL BENEFITS FOR ANY OTHER SICKNESS OR INJURY UNDER THE PLAN.

Allowed charges are:

1. In-Patient stay of at least 48 hours for the mother and newborn child following a vaginal delivery.

2. In-Patient stay of at least 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Benefit Limitations

Maternity Benefits are **NOT** payable for pregnancy expenses or resulting complications of Eligible Dependent children.

I. Mental Health Benefit

Benefits for Expenses Incurred by a Covered Person for treatment prescribed by a Legally Qualified Substance Use Professional for mental or nervous Sickness will be paid according to the Schedule of Benefits for Medically Necessary care and services. Allowed charges are:

1. Mental health evaluations and assessment,
2. Diagnosis,
3. Treatment planning,
4. Referral services,
5. Medication management,
6. Short-term individual, family and group therapeutic services (including intensive Out-Patient therapy),
7. Crisis intervention,
8. Nutritional counseling for treatment for mental or nervous Sickness, including anorexia nervosa, bulimia nervosa, and binge-eating disorder, and
9. Psychological testing.

Mental Health Benefits are **NOT** payable for:

1. Service or treatment rendered by anyone other than a Legally Qualified Substance Use Professional,
2. Any charges related to a period of confinement or frequency of treatment which is considered custodial or not reasonable for the diagnosed condition(s), or
3. Behavior disorders.

MENTAL HEALTH BENEFITS ARE PAYABLE UNDER THE MAJOR MEDICAL BENEFIT PROVISION ONLY AND ARE SUBJECT TO THE SAME TERMS, CONDITIONS AND LIMITATIONS GOVERNING THE INDIVIDUAL BENEFITS FOR ANY OTHER SICKNESS OR INJURY UNDER THE PLAN.

J. Preventive Services/Routine Services Benefit

This benefit covers certain Preventive Services, including immunizations for routine use in children, adolescents, and adults, certain preventive health screenings and additional Preventive Services for women without the imposition of a deductible, Copay or Coinsurance if the Preventive Service is provided In Network. For a current list of the covered Preventive Services benefits generally described in this Section J, contact the Fund Office or visit the following websites:

- https://www.healthcare.gov/coverage/preventive-care-benefits
- https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations
- http://www.cdc.gov/vaccines/schedules/hcp/index.html
- http://www.hrsa.gov/womensguidelines/

K. Rehabilitative Therapy Benefit

Rehabilitative Therapy for an injury or Sickness shall be **considered** under the Plan according to the Schedule of Benefits, provided the Fund Office receives a complete plan of treatment from a referring Physician. The plan of treatment must include:

1. Diagnosis,

2. Type of treatment, and

3. Anticipated length of treatment.

Benefit Limitations

Payment for rehabilitative therapy is dependent upon approval by the Plan. Your Physician should submit the plan of treatment to the Fund Office **before** beginning any rehabilitative therapy.

SMART HEALTHCARE CONSUMER TIP:

Be Prepared when you go to your Doctor's Office

Keep your scheduled appointments, especially if you are being treated for a chronic illness. Write down your symptoms and changes in your health since your last visit and keep a log of the prescription and over-the-counter medications you are taking and how often you take them. This way, you won't forget to ask important questions and give your doctor pertinent health information during your appointment.

L. Surgery – Second Surgical Opinion (Third if Necessary)

When a Covered Person wishes to secure a second or third opinion regarding the Medical Necessity for an In-Patient Surgical Procedure of a non-emergency nature, Benefits will be paid according to the Schedule of Benefits for the second or third opinion provided:

1. The Covered Person is examined in person by a board certified specialist; and the specialist Physician submits a written report of findings and recommendation, and

2. The specialist Physician who renders the second or third opinion does not also perform or assist in performing the recommended Surgical Procedure, and

3. The specialist Physician has no relationship with the Physician(s) who rendered prior opinions or who performs or assists in the Surgical Procedure.

If surgery is performed after the second or third surgical opinion, the Fund will pay the surgical fees under the Major Medical Benefit.

M. Telehealth Benefit via Blue KC Virtual Care

"BlueKC Virtual Care" provides Telehealth Benefits, and is designed to give covered persons the capability to speak with a certified physician online (with a webcam) or through a smartphone in order to get quick access to certain prescriptions or other advice regarding a medical situation. The telemedicine benefit is available 24 hours a day, 7 days a week. This benefit is not meant for emergency situations but it can help in deciding whether a medical situation is an emergency. The benefit is available at no cost to the member, as reflected in the Schedule of Benefits and it is not subject to deductible, Copay or Coinsurance. BlueKC Virtual Care is an In-Network benefit only.

N. Urgent Care Benefit

When a Covered Person requires Urgent Care, Benefits will be paid according to the Schedule of Benefits for Usual, Customary and Reasonable Charges after the deductible.

O. Genetic Testing Benefit

Effective December, 1, 2022, the Plan covers services and supplies related to genetic testing, subject to prior authorization by Avalon Healthcare Solutions. Avalon Healthcare Solutions shall provide Prior Authorization review for all genetic testing to evaluate the appropriateness of genetic testing and whether the requested genetic testing is Medically Necessary, prior to the testing being performed in accordance with their criteria.

Section Five – Prescription Drug Benefit

SMART HEALTHCARE CONSUMER TIP:

Follow the Directions on the Label

Take your medications as your doctor has prescribed them, especially antibiotics. Don't take other people's medications. If you are taking prescriptions medications, check with your doctor before taking over-the-counter remedies. They may interact with medications your doctor has prescribed for you or be inappropriate for your illness.

With the Prescription Drug Benefit, eligible Employees and Pre-Medicare Retirees will receive two prescription drug cards. A card should be presented at a participating pharmacy with each prescription drug purchase. The cards will permit eligible Employees and Retirees and their Eligible Dependents to purchase prescription drugs at a discounted price. You will only pay the required Copay when you make a purchase with the card. The Fund will pay the remaining cost.

NOT ALL BENEFITS ARE AVAILABLE TO ALL COVERED ACTIVES AND NON-MEDICARE RETIREES. THE PLAN'S BENEFITS FOR MEDICARE-ELIGIBLE RETIREES ARE DESCRIBED IN THE PLAN'S GROUP MEDICARE ADVANTAGE WITH PART D (MAPD) POLICY. PLEASE CONSULT THE APPLICABLE SCHEDULE OF BENEFITS TO DETERMINE IF YOU OR YOUR DEPENDENTS ARE ELIGIBLE FOR ANY PARTICULAR BENEFIT.

A. Retail and Mail Order

This Benefit includes both retail pharmacies and a mail order service. A prescription for a generic drug filled at a retail pharmacy can provide medication for up to 34 days or up to 90 days per Copay. A prescription for a brand name drug filled at a retail pharmacy can provide medication for no more than 34 days per Copay. A prescription filled through the mail order service can provide your medication for 90 days per Copay.

SMART HEALTHCARE CONSUMER TIP:

Save with Mail Order and Generic Drugs

Consider using mail order prescription services for maintenance drugs that you take on an ongoing basis. You should also inquire about the cost of any prescribed medications. Generic drugs often cost much less than name brands and your Physician may prescribe them if you ask. If you have any questions about mail order or your Plan's preferred brand drug formulary, please visit Sav-Rx at www.savrx.com or by phone at (866) 912-7425.

B. First Dollar Coverage

You do not have to satisfy the annual individual or family deductibles in order to have a prescription covered by the Fund. As long as you are eligible, the prescription drug that you are purchasing is covered by the Fund and you are making your purchase at a participating pharmacy, then your purchase will be covered.

C. Copays

There will be three levels of Copays. What you pay will depend upon the type of prescription drug you are purchasing and where it is being purchased (retail or mail order). The Copay levels are:

Formulary Level - Drug Type	**Retail (up to 34-day supply)**	**Retail (up to 90-day supply)**	**Mail Order (up to 90-day supply)**
Level 1 – Generic	Lesser of $10 or 100% of cost of drug	Lesser of $20 or 100% of cost of drug	Lesser of $20 or 100% of cost of drug
Level 2 – Preferred Brand Name	Greater of $25 or 25% of cost of drug	N/A	Greater of $50 or 20% of cost of drug
Level 3 – Non-Preferred Brand Name	Greater of $40 or 25% of cost of drug	N/A	Greater of $80 or 20% of cost of drug

D. Formulary Choice Guide

Some brand name drugs are very expensive and are no more effective than other medications that have a lower price. Generic drugs are often available that are chemically equal to a brand name drug. In other situations, two brand name drugs are available that treat the same condition. One may be significantly more expensive than the other. The prescription drug benefit will not tell you which medication you should purchase. That is left to you and your Physician. The benefit will hopefully encourage you to make the most cost effective purchase that is consistent with your medical needs.

You will receive a listing of the Preferred brand name drugs called a Formulary Choice Guide. You will find that most drugs require the Level 2 Copay. If a brand name drug is not part of the formulary it will be considered a non-preferred brand name drug and will require a Level 3 Copay.

If you have any questions regarding the Prescription Drug Benefit or have any problems with a purchase at a participating pharmacy, please contact Sav-Rx 24 hour Customer Service at (866) 912-7425.

E. Medicare Part D Coverage

Any Medicare-eligible Participant or Eligible Dependent covered by this Plan with active coverage who also enrolls in the Medicare Part D coverage will lose their prescription drug coverage under this Plan (but not their medical coverage). The Fund Office will be reporting to Medicare the names of the individuals that are covered by

this Plan. The Fund Office, in turn, will be advised by Medicare if duplication of coverage occurs.

If your prescription drug coverage under this Plan is terminated because you enroll in the Medicare Part D coverage, you will only have an opportunity to have your prescription drug coverage reinstated under this Plan one time each year – effective the following January 1. Between October 15 and December 7 of each year, you will have an opportunity to enroll (or re-enroll) in the Medicare Part D coverage for the upcoming calendar year. For example: If you decided to enroll in the Medicare Part D coverage for 2022, you must keep your Part D prescription coverage for one year. Between October 15 and December 7 of 2022, you will have an opportunity to decide on your coverage for 2022. You can re-enroll in the Medicare Part D coverage or you can return to this Plan for coverage (provided that you have continued your medical coverage under this Plan and that you continue to pay all of your monthly self-pay premiums on a timely basis).

F. Contact Information

If you have questions or need help determining if a pharmacy is an in-network provider for Sav-Rx or if you have questions regarding drug formulary, you will need to contact Sav-Rx. Their contact information can be found on your drug card and is as follows:

Call: 24-hour Customer Service Phone No.: (866) 912-7425

Write:

General Information:	**Mail Order:**
Sav-Rx	Sav-Rx Pharmacy
224 N. Park Avenue	P.O. Box 8
Fremont, NE 68025	Fremont, NE 68026

Website: www.savrx.com

G. Prescription Claim Appeals

For information on the appeals process, refer to Section Ten - Claims and Appeal of Denied Claims Procedures on page 57. Further questions should be directed to the Fund Office toll-free at (833) 479-9428.

H. Exclusions and Limitations

Certain classes of prescription drugs are excluded from coverage under the Plan. Please refer to Section Nine – Benefit Exclusions and Limitations beginning on page 52 for information on exclusions for prescription drugs.

From time to time the Trustees may implement special programs to control plan costs. An example of such a program is Step Therapy, as explained in subsection J, below.

I. Step Therapy

Participants seeking treatment with certain types of medications will be required to try less expensive but clinically appropriate medications, commonly referred to as 'first line drugs,' before a prescription will be covered under the Plan for what is considered a 'second line drug.' First line drugs include over-the-counter products, generic drugs and some brand name drugs. The types of medications listed below are considered 'second line drugs' and will be covered by the Plan only after first line drugs have been tried and demonstrated to be ineffective for treating the problem.

- Angiotensin II Receptor Antagonists (high blood pressure)
- BPH – Avodart
- Enhanced Bisphosphonates
- Preferred PPIs
- Fenofibrate
- Hypnotics
- Leukotriene Pathway Inhibitors
- Lyrica
- Nasal Steroid
- Non-Sedating Antihistamines
- Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) and COX-2s
- Other Antidepressants (depression)
- Preferred Overactive Bladder
- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Tekturna
- Tetracyclines - Oral
- Topical Acne
- Topical Corticosteroids
- Topical Immunomudulators

The pharmacist will advise you if you are presenting a prescription for a medication that is covered by the Step Therapy program. Sav-Rx will work with your pharmacist and doctor to implement the program but still provide you with suitable medication on a timely basis.

Section Six – Vision Benefit

If a Covered Person incurs expenses for vision care services at any vision provider, the Fund will pay Benefits according to the Schedule of Benefits.

NOT ALL BENEFITS ARE AVAILABLE TO ALL COVERED ACTIVES AND NON-MEDICARE RETIREES. THE PLAN'S BENEFITS FOR MEDICARE-ELIGIBLE RETIREES ARE DESCRIBED IN THE PLAN'S GROUP MEDICARE ADVANTAGE WITH PART D (MAPD) POLICY. PLEASE CONSULT THE APPLICABLE SCHEDULE OF BENEFITS TO DETERMINE IF YOU OR YOUR DEPENDENTS ARE ELIGIBLE FOR ANY PARTICULAR BENEFIT.

Definitions

The following definitions apply to the Vision Benefit:

"**Allowed Charges**" are:

1. Vision Screening (eye examination),
2. Visual Analysis,
3. Lenses when provided by an optometrist, Physician or optician,
4. Frames when provided by an optometrist, Physician or optician,
5. Contact Lenses when provided by an optometrist, Physician or optician, and
6. One pair of prescription or non-prescription safety glasses per calendar year.

"Vision Screening" (eye examination) means a survey of the principal visual functions in order to determine the condition of the vision. If the Vision Screening indicates a need for further work, a Visual Analysis may be necessary.

"Visual Analysis" means and includes, but is not limited to, the following:

1. Case history,
2. Examination for pathology or anomalies,
3. Refraction,
4. Visual field charting, and
5. Prescription for proper lenses.

Benefit Limitations

Vision Benefits for dependents age 19 and over will be limited to a $250 per person per Calendar Year maximum. Vision Benefit limits for Eligible Dependents under age 19 do not apply to reasonable expenses for pediatric services as required by law. Please contact the Fund Office for a list of covered pediatric services.

Section Seven – Dental Benefit

If a Covered Person incurs expenses for dental care services, the Fund will pay Benefits according to the Schedule of Benefits.

NOT ALL BENEFITS ARE AVAILABLE TO ALL COVERED ACTIVES AND NON-MEDICARE RETIREES. THE PLAN'S BENEFITS FOR MEDICARE-ELIGIBLE RETIREES ARE DESCRIBED IN THE PLAN'S GROUP MEDICARE ADVANTAGE WITH PART D (MAPD) POLICY. PLEASE CONSULT THE APPLICABLE SCHEDULE OF BENEFITS TO DETERMINE IF YOU OR YOUR DEPENDENTS ARE ELIGIBLE FOR ANY PARTICULAR BENEFIT.

When a Covered Person incurs a covered Dental Expense, the Plan will pay 80% of all reasonable dental charges subject to the $1,750 calendar year Maximum Benefit per person as set forth in the Schedule of Benefits. Covered Persons may use any Dentist that they choose. However, using a Dentist in the Connection Dental Network, may result in a lower out-of-pocket expense for the Covered Person. See page 7 for information on how to find a Connection Dental Network provider.

If a Covered Person has a life threatening illness that causes the Covered Person to incur reasonable dental charges greater than the maximum allowed, the Covered Person could receive an additional $3,500 of dental benefits for the Calendar Year. Examples of life threatening illness for the additional Dental Benefits include, but are not limited to, cancer, HIV/AIDS and lupus. The additional Dental Benefits are provided if the Covered Person receives pre-authorization from the Board of Trustees, submits a dental treatment plan indicating the requested treatment and a signed Physician's statement describing the life threatening illness that makes the additional requested treatment necessary and such documentation is submitted to the Fund Office.

The Dental Benefit is also subject to a separate lifetime maximum of $1,000 per Covered Person through age 18 for Orthodontia charges. The Orthodontia Benefit under the Plan is a stand-alone benefit irrespective of any other dental Benefits used during a Plan Year. Benefits will be paid in the same manner and with the same Copays as all other dental Benefits until the treatment is completed or the lifetime benefit maximum is met.

Definitions

The following definitions apply to the Dental Benefit:

"Calendar Year" means January 1 through December 31 of each year.

"Dental Expense" means the part of a charge for dental services which meets **all** of the following:

1. Is covered under the Dental Benefit, and

2. Does not exceed the Prevailing Fee for the service.

"Dental Hygienist" means a duly licensed dental hygienist who works under the supervision of a Dentist.

"Dentist" means a duly licensed dentist or Physician who is operating within the scope of a dentist's or Physician's license.

"Prevailing Fee" means a charge for Dental Expense which does not exceed the 90th percentile of the Plan's prevailing health care data.

Benefit Limitations

Benefits will **NOT** be paid for more than two Prophylactic Dental Examinations per calendar year, per person. Dental Benefit limits for Eligible Dependents under age 19 do not apply to reasonable expenses for pediatric services as required by law.

Section Eight – Death and Dismemberment Benefits

Active Eligible Employees Only

A. Death Benefit

Upon the death of an active eligible Employee, the Plan will pay the Benefit stated in the Schedule of Benefits to the designated Beneficiary.

If an Active Employee should die without designating a Beneficiary, the automatic Beneficiary is the Active Employee's legal Spouse, if any. If the Active Employee is not married or is not survived by a legal spouse, the automatic Beneficiary(s) shall be Active Employee's surviving children, equally, and if none, the Participant's estate.

Notwithstanding the foregoing, if any Active Employee names his/her Spouse as his/her Beneficiary and then the Active Employee and Spouse subsequently divorce, that Beneficiary designation is void and of no effect. If the Active Employee desired to name his/her ex-spouse as his/her Beneficiary, the Active Employee must fill out another Beneficiary designation from after the divorce. Failure to fill out a new form will mean that any Death Benefit shall be paid in accordance with the paragraph above.

A Beneficiary under this Section may disclaim the Death Benefit stated in the Schedule of Benefits by completing a qualified disclaimer approved by the Board of Trustees and submitting same to the Fund Office no later than 12 months after the death of the Active Employee. The qualified Disclaimer will be treated for this purpose as though the Active Employee dies without a designating a Beneficiary, and such benefit will be paid in accordance with this section.

B. Accidental Death and Dismemberment Benefit

When bodily injury to an Active Employee caused solely by an Accident shall result in any of the following losses within 90 days after the date of the Accident, the Plan will pay the benefit stated in the Schedule of Benefits and in the table below.

Loss	Amount
Life	$10,000
Both Hands or Both Feet	$10,000
Entire Sight of Both Eyes	$10,000
One Hand **and** One Foot	$10,000
One Hand **or** One Foot **and** Entire Sight of One Eye	$10,000
One Hand **or** One Foot	$ 5,000
Entire Sight of One Eye	$ 5,000

Definition

The following definition applies to the Accidental Death and Dismemberment Benefit:

"Loss" with reference to the hand or foot means complete severance through or above wrist or ankle joint, and with reference to the eye means the irrevocable loss of the entire sight thereof. In the event of multiple losses, Benefits will be paid for the greatest loss sustained as a result of any one Accident.

Benefit Limitations

Benefits will **NOT** be paid for any loss caused by:

1. Injuries suffered during combat, war or act of war,

2. Injuries which were intentionally self-inflicted unless the injury is in connection with a medical condition, and

3. Aircraft, except when the eligible Employee is a passenger in a licensed aircraft (other than chartered aircraft) operated by a licensed pilot on a regularly scheduled passenger flight offered between specified airports by a licensed passenger carrier.

Section Nine – Benefit Exclusions and Limitations

The Plan provides Benefits only for those Medically Necessary covered services and charges expressly described in the Plan. **Any omission of service or charge shall be presumed to be an exclusion even though not expressly stated as such.**

Please note, Medicare Retirees and spouses covered by the Plan's group Medicare Advantage with Part D (MAPD) program are subject to a separate list of benefit exclusions and limitations set forth in the Plan's MAPD policy.

IF YOU ARE UNSURE WHETHER A MEDICAL SERVICE OR PROCEDURE IS COVERED, PLEASE CONTACT THE FUND OFFICE FOR CLARIFICATION. FAILURE TO DO SO COULD RESULT IN YOU BEING RESPONSIBLE FOR ANY NON-COVERED OR EXCLUDED CHARGES YOU INCUR.

Benefits **WILL NOT** be paid for or shall be limited as follows:

1. Loss caused by accidental bodily injury, disease or Sickness which arises out of or occurs in the course of any occupation or employment for wage or profit; loss caused by any accidental bodily injury, disease or Sickness for which the Covered Employee claims to be, or may claim to be, or is entitled to any benefits under any Worker's Compensation or occupational disease law. The Fund retains the option to withhold payment of Benefits for treatment of any injury, disease or Sickness which may be compensable under a Worker's Compensation or occupational disease law.

2. Hospital, medical or surgical treatment provided because of loss suffered in war or while in Military Service.

3. Any service furnished by an institution which is primarily a place of rest, a place for the aged, a nursing home, a convalescent home or any institution of like character or for convalescent or custodial services.

4. Routine foot care procedures such as the trimming of nails, corns or calluses, fallen arches or other symptomatic complaints of the feet, impression casts for prosthetics and appliances, including prescriptions for orthotics.

5. Services, supplies, procedures and drugs which are not customary and generally accepted by the medical profession and services, supplies, procedures and drugs which are experimental or for the purpose of research.

6. Services or supplies related to sexual dysfunction.

7. Visual analysis, eye examination or the correction of vision, eyeglasses, fitting of eyeglasses, therapy or training for muscular imbalance of the eye, or fitting of glasses or orthotics, except as stated under the Vision Benefit.

8. Prescription or non-prescription safety glasses, except for the one pair covered under the Vision Benefit each calendar year.

9. Services provided by an audiologist when not performed in connection with a Sickness, devices to improve hearing and their related fittings, except as stated under the Hearing Aid Benefit.

10. Expenses related to treatment or services for Accident or Sickness rendered prior to the Covered Person's becoming eligible for Benefits or after losing eligibility for Benefits, except as stated under the Dental Benefit provisions.

11. Rehabilitation therapy for an injury, unless performed by a licensed physiotherapist, subject to pre-authorization by the Board of Trustees and a complete treatment plan is submitted to the Fund Office by the referring Physician.

12. Loss suffered for which a contributing cause was the Covered Person's commission of or attempt to commit a felony or the Covered Person's engaging in an illegal occupation.

13. Any Expense Incurred for obesity or morbid obesity such as weight reduction programs, weight reduction drugs, non-surgical treatments and procedures and reversion of such procedures, as well as cosmetic or other surgery for removal of excess fat or skin following (1) weight loss (unless Medically Necessary) or (2) pregnancy, regardless of Medical Necessity or supervision by a Physician. Complications from any excluded expenses are also excluded. Notwithstanding the foregoing, expenses incurred for bariatric surgery under the Bariatric Surgery Benefit and not excluded, subject to the deductible, any applicable Coinsurance and the lifetime benefit maximum.

14. Treatment or services in connection with an elective abortion.

15. Tooth extractions or other dental work or surgery that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease or disease of the gingival tissue except as otherwise provided under the Dental Benefit, or when treatment is provided within 120 days following an accidental injury to the jaw, sound natural teeth, mouth or face.

16. Any dental treatment, including treatment pertaining to the periodontium, except as covered under the Dental Benefit.

17. The maximum payable for either the initial purchase and/or replacement of prosthetic appliances shall be limited to the UCR Charge with a lifetime maximum of $25,000 per Covered Person.

18. Alternative Treatments as defined by the Office of Alternative Medicine of the National Institutes of Health except for as provided for in the Acupuncture Treatment Benefit. Examples of some treatments not covered are aromatherapy, hypnotism, massage therapy and rolfing.

19. Treatment for behavioral disorders, including conduct and impulse control disorders.

20. Charges for personal care items that are primarily for personal comfort or convenience, including, but not limited to, diapers, bathtub grabbers, handrails, lift chairs, over-bed tables, incontinence pads, ramps, snug seats, recreational items, home improvements and home appliances, spas, wigs and braces for sports.

21. Charges for motor driven wheelchairs or scooters, implantable spinal column stimulator unless such stimulator is pre-authorized by the Board of Trustees and a signed Physician's statement is submitted to the Fund Office describing Medical Necessity, ThAIRapy vests or non-standard equipment of any type. Any equipment that does not meet the covered Durable Medical Equipment criteria on page 37, is NOT a covered Benefit. Any nondurable supplies related to equipment that is not covered will also not be a covered Benefit.

22. Services for cosmetic and reconstructive surgery except: (a) as a result of a surgical procedure for which Benefits were paid under the Plan, (b) for reconstruction of a breast on which a mastectomy has been performed, for surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance, or for coverage for prostheses and physical complications of all states of mastectomy (including lymphedemas) in a manner determined in consultation with the attending Physician and the patient.

23. Fertility treatments, artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, penile prosthesis and any related prescription medication treatment.

24. Genetic or chromosomal testing services and supplies, unless prior authorized by Avalon Healthcare Solutions and deemed medically necessary prior to testing being performed;

25. Genetic counseling or gene therapy, including any services, supplies and/or drugs. Gene therapy includes any treatment, procedure or drug that uses genes to treat or prevent disease.

26. Treatment of hair loss including wigs, toupees, hairpieces, hair implants or transplants and drugs to treat hair loss.

27. Home Health Care except as provided for under the Hospice Benefit. The following are examples of excluded services:

    a. Visiting teachers, friendly visitors, vocational guidance and other counselors, and services related to diversional occupational and social activities,

    b. Services rendered by registered or licensed practical nurses, other health professionals and other allied health workers who are not employed by or functioning pursuant to a contractual arrangement with a Community or Hospital Home Health Care Agency, and

    c. Services provided to persons who are not essentially homebound for medical reasons.

28. Expenses Incurred for contraceptives and related supplies except as provided under the Preventive Services/Routine Care Benefit.

29. Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism.

30. Physical conditioning programs such as athletic training, bodybuilding, exercise fitness, flexibility and diversion or general motivation.

31. Biopharmaceutical medications.

32. Services and supplies for which the individual is not legally required to pay for or which no charge would be made if this coverage did not exist.

33. Maternity or obstetrical services for a dependent child in connection with pregnancy or resulting complications, except as provided under the Preventive/Routine Care Benefit.

34. Any treatment not considered Medically Necessary.

35. Any expenses not actually incurred by a Covered Person.

36. Any expenses for treatment of temporomandibular joint (TMJ) syndrome.

37. Any expenses for dental x-rays except as covered under the Dental Benefit.

38. Charges made by an assistant surgeon unless assistance is considered Medically Necessary.

39. Treatment for injuries sustained while participating in hazardous activities including but not limited to hang gliding; bungee jumping; parachuting; participating in any competitive motor sport, or motor racing, including training or practice for the same; participating in competitive fighting such as mixed martial arts; or traveling, operating, or learning to operate as student, pilot, or crew any kind of aircraft, including but not limited to a glider, a seaplane or hang kite as a student, pilot, or crew member.

Section Ten – Claims and Appeal of Denied Claims Procedures

The following procedure to process claims and appeals will apply to any claim filed with the BAC Local Union 15 Welfare Plan (Fund). These procedures have been adopted to comply with regulations issued by the U.S. Department of Labor, at 29 CFR 2560.503.1. For all claims filed prior to the date this Restated Plan Document and Summary Plan Description, procedures are on file with the Fund Office.

Please note, Medicare Retirees and spouses covered by the Plan's group Medicare Advantage with Part D (MAPD) program are subject to separate claims and appeal procedures described set forth in the Plan's MAPD policy.

The Board of Trustees (Board) is both the Plan Administrator and the fiduciary responsible for all benefit determinations on appeal. The Board may delegate all fiduciary responsibility for claims determination to an Appeal Committee (Committee). Such Committee shall meet once each calendar quarter at regularly scheduled times.

The Board or Committee shall have the authority to interpret, construe and apply all terms of the Restated Plan Document and Summary Plan Description, the Trust Agreement and/or any rules and regulations established by the Trustees including, but not limited to, provisions concerning eligibility for, entitlement to and/or nature, amount and duration of Benefits, in making an initial benefit determination and a determination on appeal.

Under Federal law, a Covered Person or Beneficiary has the right to bring a civil action under ERISA Section 502(a), if dissatisfied with an adverse benefit determination. Before bringing such an action, the Covered Person or Beneficiary must exhaust the Plan's Claims and Appeal of Denied Claims Procedures. Any such legal action against the Plan under ERISA must be filed within two years of the date of the decision of the Trustees on appeal.

A. Definitions

1. Medical Claim
   A **"Medical Claim"** is a written or Health Insurance Portability and Accountability Act (HIPAA) compliant electronic post-service request for payment of Benefits from the Fund:

   a. Made by a Claimant,

   b. Received by the Fund Office or applicable PPO within one year of the date of service, and

   c. Includes all of the following:

      i. Participant's Name,

      ii. ID Number,

iii. Address,

iv. Patient Name/Date of Birth/Relationship to Participant,

v. Claimant authorization to pay/or not,

vi. ICD-9 diagnosis code,

vii. Date of Service,

viii. Place of Service,

ix. CPT procedure codes,

x. Charges,

xi. Provider Federal ID Number, Name and Address, and

xii. Patient account number.

d. A claim is **NOT:**

i. A verbal inquiry about whether a specific service is a covered benefit.

ii. A voluntary pre-service determination of whether a treatment, service or product is covered.

iii. An inquiry regarding eligibility to receive a treatment, service or product. However, after service is incurred, a determination of eligibility will be made by the Fund.

iv. An attempt to purchase or receive a prescription drug at the counter. However, any denial of such purchase or receipt entitles the Claimant to file a claim after the denial.

2. Disability Claim

A **"Disability Claim"** is a claim for benefit for the active disabled Employee's hours credit of 30 hours worked per week for a maximum of 13 weeks as described in the Section Two "Eligibility Rules" at Subsection G., Eligibility for Active Disabled Employees; or a claim for Accidental Death & Dismemberment Benefits.

3. Claimant
A **"Claimant"** is:

   a. An eligible Participant in the Fund,

   b. An Eligible Dependent, or

   c. The duly appointed Authorized Representative of an eligible Participant or Eligible Dependent, as described below.

4. Authorized Representative
An **"Authorized Representative"** is a person who is specially designated by a Claimant to represent the Claimant in respect to a claim for Benefits or an appeal of a denied claim. In order to designate an Authorized Representative, the Claimant must present to the Fund Office a written statement designating an Authorized Representative. For your convenience, a "Designation of Authorized Representative" form is available at the Fund Office. The statement must include:

   a. The name, telephone number and mailing address of the Authorized Representative,

   b. The name, mailing address, date of birth and Social Security number of the Claimant, and

   c. The signature of the eligible Participant or, in the case of an Eligible Dependent, the individual or a minor child's parent or legal guardian.

   The Board of Trustees has the sole discretion to determine whether a Claimant has properly designated an Authorized Representative.

   Assigning a health care provider the right to receive Benefits does not make the provider an Authorized Representative. Any individual wishing to designate a health care provider as an Authorized Representative must provide the Fund Office with a separate written statement designating the provider as such. For your convenience, a "Designation of Authorized Representative" form is available at the Fund Office.

   If a Claimant has designated an Authorized Representative, the Authorized Representative will receive all information and notifications, and will be authorized to act on behalf of the Claimant, with respect to all aspects of the claim. This includes, but is not limited to, the initial determination, requests for documents, appeals, and any other communication regarding the claim. The authorization will remain in effect unless or until the Claimant provides the Fund Office with written notification that restricts or cancels the authorization.

5. Days
"Days," for purposes of computing any time period under this Section, shall mean calendar days.

B. Filing Medical Claims

When you receive medical services at a PPO provider, you should present your medical benefits identification card (ID card) at the time of service. Generally, if you use a PPO provider, the provider will submit a Medical Claim directly to the Fund Office or the entity responsible for processing Medical Claims.

Most health care providers will file Medical Claims for you. Be sure to show your ID card so your provider knows where to submit your claim. If your provider does not submit a claim for you, you or your Authorized Representative should file a claim as soon as possible after you receive medical services, but in no event should a claim be filed later than one year from the date you receive medical services or your Medical Claim will be denied.

If you need to submit a **Medical Claim** for medical services, you should submit an itemized statement or bill that details the charges to:

Blue Cross Blue Shield of Kansas City
PO Box 419169
Kansas City, MO 64141-6169

If you need to submit a **Vision Claim** for vision services, submit an itemized statement or bill that details the charges to:

BAC Local Union 15 Welfare Fund
PO Box 909500
Kansas City, MO 64190
Fax: (816) 756-3659

When filing a claim:

1. If your claim is for healthcare that is also covered by Medicare, attach a copy of the itemized bill relating to the health service provided and a copy of Medicare's explanation of benefits. Both the bill and Medicare's explanation of benefits should be submitted.

2. If a claim is for an Eligible Dependent, provide the name of the Eligible Dependent.

3. If you or an Eligible Dependent has coverage under more than one plan, be sure to include the name of the other plan(s).

C. Time Periods for Initial Determination

1. Medical Claims
The Fund will make its initial benefit determination within 30 Days of receipt of the claim. The Fund may extend this initial benefit determination period 15 additional Days. The Fund will notify the Claimant within the first 30 Days, if an extension will apply. If additional information is needed to process the claim, the Fund will give the Claimant 45 Days to provide this additional information. The request for additional information may include a notice to the Claimant that the claim is denied, in whole or in part, if the requested information is not provided within the 45 day period.

2. Disability Claims
The Fund will make its initial determination within 45 Days. The Fund may extend this initial benefit determination up to two times of 30 additional Days each. The Fund will notify the Claimant if an extension will apply before the end of each previous determination deadline. If additional information is needed to process the claim, the Fund will give the Claimant 45 Days to provide this additional information. The request for additional information may include a notice to the Claimant that the claim is denied, in whole or in part, if the requested information is not provided within the 45 day period.

SMART HEALTHCARE CONSUMER TIP:

Review Your Explanation of Benefits Forms

Make sure that the services your Plan has paid for were actually provided. If you do not recognize the name of the Provider, or did not go to the doctor on the date of service shown on the form, call the contract claims administrator.

D. Notice of Initial Determination

The Fund will issue a written or HIPAA compliant electronic notice of benefit determination, which may be a denial of Benefits, also known as an adverse benefit determination. This notice is also called an "Explanation of Benefits," or EOB. This notice will contain:

1. The specific reason or reasons for the adverse determination.

2. Reference to the specific benefit provisions on which the determination is based.

3. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information in necessary.

4. A description of the Fund's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

5. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion shall be provided to the Claimant; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the Claimant upon request.

6. If the adverse benefit determination is based on a Medically Necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the benefit Plan to the Claimant's medical circumstances shall be provided to the Claimant, or a statement that such explanation will be provided free of charge upon request.

7. The initial adverse benefit determination shall contain a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

   a. The views presented by you to the plan from health care professionals treating you and vocational professionals who evaluated you;

   b. The views of medical and vocational experts whose advise was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

   c. A disability determination by the Social Security Administration regarding yourself, presented by you to the plan.

8. The adverse benefit determination will be provided to you in a culturally and linguistically appropriate manner when your address is in a county where 10 percent or more of the population in literate only in the same non-English language.

E. Time Periods for Appeals – Medical and Disability Claims

A request for review (an appeal) must be submitted in writing to the Fund Office no later than 180 Days after the Claimant's receipt of the notice of adverse benefits determination. The Board of Trustees may delegate to an Appeal Committee the authority to make all benefit determinations on appeal. The Fund shall issue a benefit determination on appeal no later than the next regularly scheduled quarterly meeting of the Appeal Committee of the Board of Trustees. Except that if the appeal is received by the Fund less than 30 Days before the next quarterly Appeal Committee meeting, a benefit determination on appeal shall be made no later than the second quarterly committee meeting after the receipt of the appeal. In addition, if, due to circumstances beyond the control of the Fund, a decision still cannot be made by that

time, the Fund may extend the period to make a determination until the next quarterly meeting. If the Claimant requests a hearing, a benefit determination shall be made no later than the third Appeal Committee meeting after receipt of the appeal.

The Fund shall issue its decision no later than five Days following the benefit determination.

F. Claimant's Rights on Appeal

The following rules govern the Claimant's rights on appeal:

1. As stated in Subsection D above, a Claimant shall have at least 180 Days following receipt of a notification of an adverse benefit determination within which to appeal the determination.

2. The review on appeal shall not give deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Fund who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

3. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

4. The Plan shall provide to Claimant the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

5. The appeal review process shall provide that the health care professional engaged for purposes of a consultation under Paragraph 3 of this Subsection E shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

6. The written decision of the Appeal Committee shall be final, binding and conclusive upon the Claimant.

7. All review procedures described above must be followed and exhausted before a Claimant may institute any legal action including an action or proceeding before any court, administrative agency or arbitrator (legal body). Generally, such legal bodies require a Claimant to follow and exhaust the Fund's review procedures before allowing a Claimant's legal action to proceed. If a Claimant files a legal action before following and exhausting the Fund's review procedures, this may result in a negative ruling by the relevant legal body and impair or cause the loss of the right to bring any further legal action.

8. Before and adverse benefit determination on appeal is issued, you will be provided, free of charge, with any new or additional evidence considered, relied upon or generated by the plan, insurer, or other person making the benefit determination (or at the direction of the plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on appeal is required to be provided in order to give you a reasonable opportunity to respond prior to that date.

9. Before and adverse benefit determination on appeal is issues based on new or additional rationale, you will be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on appeal is required to be provided in order to give you a reasonable opportunity to respond prior to that date.

10. If the plan fails to strictly adhere to all the requirements of this section with respect to a claim, then you will be deemed to have exhausted the administrative remedies available under the plan, except as provided in Paragraph 11 of this Subsection E. Accordingly, you are entitled to pursue any available remedies under Section 502(a) of the Act on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to pursue remedies under Section 502(a) of the Act, the claim or appeal is deemed denied on appeal without the exercise of discretion by the Trustees.

11. Notwithstanding Paragraph 10 of this Subsection E, the administrative remedies available under the plan with respect to claims for disability benefits will not be deemed exhausted on de minimis violations that do no cause , and are not likely to cause prejudice or harm to you so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the plan. This exception is not available if the violation is part of a pattern or practice of violations of the plan. You may request a written explanation of the violation from the plan, and the plan must provide such explanation within 10 days, including a specific description of the bases, if any, for asserting that the violation should not cause the administrative remedies available under the plan to be deemed exhausted. If a court rejects your request for immediate review under Paragraph 10 of this Subsection E, the claim shall be considered as re-filed on appeal upon the plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the plan shall provide you with notice of the resubmission.

G. Content of Notice of Benefit Determination on Appeal

The Plan Administrator will provide a Claimant with written or electronic notification of the Fund's benefit determination on review. Any electronic notification shall comply with the standards imposed by law. In the case of an adverse benefit determination, the notification will include the following, in a manner that is understood by the Claimant:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific benefit provisions on which the determination is based;

3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for Benefits.

4. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion shall be provided to the Claimant; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the Claimant upon request; or

5. If the adverse benefit determination is based on a Medically Necessary or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the benefit Plan to the Claimant's medical circumstances shall be provided to the Claimant, or a statement that such explanation will be provided free of charge upon request.

6. A statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA.

7. The statement of your right to bring an action under Section 502(a) will describe any applicable contractual limitations period, and will include the calendar date on which said period expires for your claim.

8. The adverse benefit determination on appeal shall contain a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

    a. The views presented by you to the plan from health care professionals treating you and vocational professionals who evaluated you;

b. The views of medical or vocational experts whose advise was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

c. A disability determination by the Social Security Administration regarding yourself, presented by you to the plan.

9. The adverse benefit determination on appeal will be provided to you in a culturally and linguistically appropriate manner when your address is in a county where 10% of more of the population is literate only in the same non-English language.

H. Hearing Procedure

The Board of Trustees establishes the following procedures for hearings:

1. The Claimant and/or duly Authorized Representative shall be afforded an opportunity to appear before the Appeal Committee and shall have the right and opportunity to examine witnesses, produce documents and other evidence material to the claim.

2. The proceeding of the hearing shall be preserved by means of meeting minutes or as authorized by the Trustees.

3. In conducting the hearing, the Appeal Committee shall not be bound by the usual common law or statutory rules of evidence.

4. The Claimant or Authorized Representative shall have the right to review the minutes of the hearing, obtain a reproduced copy thereof and obtain a copy of all documents and records introduced or referred to. The cost of copies or documents shall be 25¢ per page.

5. There shall be copies made of all documents and records introduced at the hearing, and the copies shall be attached to the record of the hearing and made a part thereof and shall be retained in the Claimant's file.

6. All information upon which the Appeal Committee bases its decision shall be disclosed to the Claimant or Authorized Representative at the hearing or in a written decision.

I. Fraudulent Claim Warning

Any person who knowingly and with intent to defraud files a statement of claim or assists anyone else in filing such a statement of claim which contains any material with false information, or conceals for the purpose of misleading information concerning any fact material hereto, commits a fraudulent act which is a crime. In the event that such a claim is submitted by a Participant or anyone else, the claim would

be denied and the full sanctions under the law would be followed. In the event any claim is paid as the result of such a fraudulent statement or submission, which is determined to be fraudulent, the full penalty of the law will be applied and the amount of the claim paid will be recovered with interest.

For example, if you are married and become divorced, you must notify the Fund Office immediately. If you fail to do so and your former spouse incurs medical expenses which are covered by the Plan, you may be held liable for those expenses as outlined above. If you let any individual who is not eligible under the Plan as a member of your immediate family use your Plan identification card to obtain medical care, you may be held liable for the Plan's attorney's fees.

As noted, participating in allowing others who are not eligible for Benefits under the Plan, as in the aforementioned examples, is considered fraud and could also possibly subject you and the ineligible individuals who incur such expenses to criminal prosecution. Further in the event such expenses are incurred by ineligible individuals due to your active or passive participation (i.e. failing to report to the Fund Office a divorce or the use of your Plan identification card by an ineligible individual) the Plan may offset any such expenses against any expenses you, your Eligible Dependents or new spouse, if you remarry, may incur. In other words, the Plan may not pay such expenses until the amount of expenses that were improperly paid have been offset in full against any expenses that Plan would otherwise have paid.

J. Limitation on when a Lawsuit May be Filed to Obtain Benefits

A Claimant may not start a lawsuit to obtain benefits until after:

1. The Claimant has requested an appeal and a final decision has been reached on appeal; or

2. until the appropriate timeframe described in the claim and appeal section of the Plan has elapsed since you filed a request for appeal and you have not received a final decision or notice from the Board that an extension will be necessary to reach a final decision.

For claims incurred on or after April 1, 2015, any lawsuit brought against the Plan must be initiated no more than two years after the date of:

1. a determination denying the claim for benefits; or

2. the time for a decision on an appeal has expired.

K. Mandatory Litigation Venue.

A Participant or Beneficiary shall only bring an action in connection with the Plan in the U.S. District Court for the Western District of Missouri.

L. External Review of No Surprises Act Claims

If your claim for benefits related to protections provided by the No Surprises Act as detailed in Section Twelve, subsection K has been denied (i.e. you received an adverse benefit determination on such claim from the Plan), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for External Review of the determination.

1. Request for External Review

An external appeal must be allowed if the Claimant requests an external appeal within four months after receipt of notice of adverse benefit determination on appeal. An immediate external review must also be allowed if the Plan has failed to adhere to the appeals regulations unless the violation was:

a. de minimis;
b. non-prejudicial;
c. attributable to good cause or matters beyond the Plan's control;
d. in the context of an ongoing good-faith exchange of information; and
e. not reflective of a pattern or practice of non-compliance.

If the Plan asserts an exception, the claimant is entitled, upon written request, to an explanation of the Plan's basis for asserting the exception. If the external reviewer rejects the Claimant's request for immediate review on the basis that the Plan has met the five-element exception, the claimant is permitted to resubmit and pursue and internal appeal.

2. Preliminary Review

The preliminary review of the external appeal must be completed within five business days after receipt of request to determine whether:

a. The Claimant was covered under the Plan at the time the health care item or service was provided;

b. The initial claim denial or adverse benefit determination on appeal did not relate to the Claimant's failure to meet eligibility requirements for eligibility under the Plan;

c. The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the regulations; and

d. The Claimant has provided all the information and forms required to process an External Review.

Within one business day after completion of preliminary review, the Plan must issue notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (call toll-free (866) 444-EBSA (3272)). If the request is not complete, such notification must describe the information and materials needed to make the request complete and the Plan must allow the Claimant to perfect the request for external review within the four month filing period or within the 48 hour period following the receipt of notification, whichever is later. Note that for an urgent care issue, the preliminary review must be done immediately and the claimant must be notified of the decision immediately.

3. Referral to Independent Review Organization (IRO)

The Plan must utilize an independent review organization (IRO) that is accredited by the Utilization Review Accreditation Commission (URAC) or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan must take action against bias and ensure independence.

Accordingly, the Plan must contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased methods for selection of IROs, such as random selection). The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. The IRO process may not impose any costs, including filing fees, on the claimant requesting the external review.

Within five business days after assignment to an IRO, the Plan must provide all documents and information considered in denying the appeal to the IRO. The IRO must provide written notice of its decision within 45 days of assignment. For urgent care issues, the IRO must provide notice of its decision as soon as possible but in no event more than 72 hours after receipt of the request for expedited external review.

4. Implementation of Reversal

Upon receipt of notice of final external review decision reversing an adverse benefit determination, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits for claim).

Section Eleven – Use and Disclosure of Protected Health Information

A. This Section of the Plan is adopted to effect compliance with the Health Insurance Portability and Accountability Act of 1996 and the Regulations issued thereunder by the Secretary of Health & Human Services concerning the privacy of protected health information (together referred to herein as The Privacy Rule). The Privacy Rule is incorporated herein by reference.

B. All capitalized terms have the meaning as stated in this Restated Plan Document and Summary Plan Description or The Privacy Rule.

C. This Section establishes the required and permitted uses and disclosures of Protected Health Information (PHI) by the Plan Sponsor, which is the Board of Trustees. The Board of Trustees is also the Plan Administrator under the Employee Retirement Income Security Act of 1974 (ERISA).

D. PHI may be used by and disclosed to the Board of Trustees or individual Trustees for purposes of general administration of the Plan, as follows:

1. Underwriting and budgeting;

2. Claims review and processing;

3. Amending or modifying the Plan of benefits (plan design);

4. Claims assistance;

5. Eligibility review;

6. Any and all general administration of the Plan.

E. PHI may be disclosed to the Board of Trustees, or individual Trustees as authorized by an individual.

F. The BAC Local Union 15 Welfare Fund shall make reasonable efforts to limit disclosure and use of PHI to the Board of Trustees to the minimum necessary to accomplish the intended use or disclosure.

G. The Board of Trustees:

1. Shall not use or further disclose PHI other than as permitted or required by this Restated Plan Document and Summary Plan Description or as required by law.

2. Shall comply with verification procedures of the group health plan.

3. Shall ensure adequate separation between the group health plan and the Plan Sponsor as follows:

    a. Describe those employees or classes of employees or other persons under the control of the plan Sponsor to be given access to the PHI to be disclosed, provided that any employee or person who receives PHI relating to treatment, payment under, health care operations of, or other matters pertaining to the group health plan in the ordinary course of business must be included in such description;

    b. Restrict the access to and use by such employees and other persons described in paragraph (G)(3)(a) of this Section to the Plan administration functions that the Plan Sponsor performs for the group health plan; and

    c. Provide an effective mechanism for resolving any issues of noncompliance by persons described in paragraph (G)(3)(a) of this Section with the Plan Document provisions required by this paragraph.

4. Shall not use or disclose PHI for employment related decisions.

5. Shall ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.

6. Shall not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual or pursuant to a Business Associate contract.

7. Shall report to the Plan any use or disclosure of the information that is inconsistent with the allowed uses or disclosures of which it becomes aware.

8. Shall make PHI available to the Plan when the Plan is requested by an individual to gain access to PHI in accordance with the access requirements of HIPAA.

9. Shall make PHI available to the Plan when the Plan is requested by an individual for amendment and incorporate any amendments to PHI in accordance with HIPAA.

10. Shall make available to the Plan the information required to provide an accounting of disclosures.

11. Shall make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of HHS for the purposes of determining compliance by the Plan with HIPAA, and

12. Shall return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.

H. Each Trustee shall certify compliance with the Rule and the Privacy Policy of the BAC Local Union 15 Welfare Fund.

I. This provision of Section Eleven of the Plan concerning security of electronic PHI is adopted to further comply with The Security Rule, which is incorporated herein by reference. The Board of Trustees shall:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

2. Ensure that the adequate separation discussed above in Paragraph G, subparagraph 3, specific to electronic PHI, is supported by reasonable and appropriate security measures;

3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and

4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

The terms electronic protected health information, electronic PHI and e-PHI, as used in the Plan, mean protected health information that is transmitted by or that is maintained in an electronic media, including but not limited to: magnetic tape, computer hard drive, computer disks, CDs, CD-ROM, flash memory devices, backup tapes or disks, etc.

Section Twelve – Administrative Information

The following topics are discussed under this Section on Administrative Information:

A. Coordination of Benefits

Please note, Medicare Retirees and spouses covered by the Plan's group Medicare Advantage with Part D (MAPD) program are not subject to these Coordination of Benefits provisions.

The following rules govern the Coordination of Benefits:

1. Applicability
   This Coordination of Benefits (COB) provision applies to This Plan when a Participant or a Participant's Eligible Dependent has health care coverage under more than one plan. "This Plan" and "Another Plan" are defined below.

   If this COB provision applies, the Order of Benefit Determination Rules in Subsection 3 below should be looked at first. Those rules determine whether the Benefits of This Plan are determined before or after those of Another Plan. The Benefits of This Plan:

   a. Will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its Benefits before Another Plan (This Plan pays first); but

   b. May be reduced when, under the Order of Benefits Determination Rules, Another Plan determines its benefits first (This Plan pays second). The above reduction is described in Subsection 4, "Effect of the Benefits of This Plan".

2. Definitions

   a. **"Allowable Expense"** means a necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private Hospital room will not be considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in This Plan.
When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When Benefits are reduced under a Primary Plan because a Covered Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, authorization of admissions or services and preferred provider arrangements.

b. **"Another Plan"** is any of the following which provides benefits or services for, or because of, medical or dental care or treatment that is not BAC Local Union 15 Welfare Fund:

   i. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

   ii. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time, including Medicare Part D).

   Each contract or other arrangement for coverage under i. or ii. above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

c. **"Claim Determination Period"** means a calendar year. However it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

d. **"Primary Plan/Secondary Plan"** is determined using The Order of Benefit Determination Rules.

   When This Plan is a Primary Plan, its Benefits will be determined before those of Another Plan and without considering Another Plan's benefits.

   When This Plan is a Secondary Plan, its Benefits will be determined after those of Another Plan and may be reduced because of Another Plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

e. **"This Plan"** is BAC Local Union 15 Welfare Fund.

3. Order of Benefit Determination Rules

a. General
When there is a basis for a claim under This Plan and Another Plan, This Plan shall be Secondary Plan which has its benefit determined after those of Another Plan, unless:

i. The other Plan has rules coordinating its benefits with those of This Plan; and

ii. Both those rules and This Plan's rules, in Subsection b. below, require that This Plan's Benefits be determined before those of the other plan.

b. Rules
This Plan shall determine its order of Benefits using the **first** of the following rules that apply:

i. Non-Dependent/Dependent
The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) shall be determined before those of the plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVII of the Social Security Act and implementing regulations, Medicare is Secondary to the plan covering the person as a dependent and Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent. This Plan will not coordinate with Medicare Part D.

ii. Dependent Child/Parents not Separated or Divorced
Except as stated in Paragraph iii. below, when This Plan and Another Plan cover the same child as a dependent of different persons, called "parents," the benefits of the plan of the parent whose birthday (month and day) falls earlier in a year shall be determined before those of the plan of the parent whose birthday (month and day) falls later in that year. But if both parents have the same birthday (month and day), the benefits of the plan which covered one parent longer will be determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in this Paragraph ii., but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

iii. Dependent Child/Separated or Divorced

If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child shall be determined in this order:

(a) First, the plan of the parent with custody of the child;

(b) Then, the plan of the spouse of the parent with the custody of the child; and

(c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan shall be determined first. The plan of the other parent shall be the Secondary Plan. This Paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

iv. Joint Custody

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph ii., above.

v. Married Dependent Child

If a dependent child is married, benefits for the child shall be determined in this order:

(a) First, the plan that covers the child as an employee;

(b) Then, the plan of the child's spouse that covers the employee as a dependent; and

(c) Finally, the plan of the parent that covers the employee as a dependent.

vi. Active/Inactive Employee
The benefits of a plan which covers a person as an employee who is neither laid off nor retired shall be determined before those of a plan which covers that person as a laid off or retired employee. The same is true if a person is a dependent of a person covered as a Retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

vii. Continuation Coverage
If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under Another Plan, the following will be the order of benefit determination:

(a) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

(b) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

viii. Longer/Shorter Length of Coverage
If none of the above rules determines the order of benefits, the benefits of the plan which covered the employee, member or subscriber longer will be determined before those of the Plan which covered that person for the shorter term.

4. Effect on the Benefits of this Plan
The following rules govern the effect on the benefits of these COB rules:

a. When this Section Applies
This Subsection 4 applies when, in accordance with Subsection 3 "Order of Benefits Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event, the Benefits of This Plan may be reduced under this Section. Such other plan or plans are referred to as "Another Plan" in Subsection b. ii., below.

b. Reduction in This Plan's Benefits
The Benefits of This Plan will be reduced when the sum of:

i. The Benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision, and

ii. The benefits that would be payable for the Allowable Expenses under Another Plan, in the absence of provisions with a purpose like that of

this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period.

In that case, the Benefits of This Plan will be reduced so that they and the benefits payable under Another Plan do not total more than those Allowable Expenses.

When the Benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

c. Right to Receive and Release Needed Information
Certain facts are needed to apply these COB rules. This Plan has the right to decide which facts it needs. To the extent allowed under law, This Plan may get needed facts from or give them to any other organization or person. This Plan need not inform or get the consent of any person to do this, unless required to do so by law. Each person claiming Benefits under This Plan must give any facts This Plan needs to pay the claim.

d. Facility of Payment
A payment made under Another Plan may include an amount which should have been paid under This Plan. If it does, This Plan may pay that amount to the organization which made the payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

e. Right of Recovery
If the amount of the payments made by This Plan is more than it should have paid under this COB provision, This Plan may recover the excess from one or more of:

i. The persons it has paid or for whom it had paid,

ii. Insurance companies, or

iii. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

B. Determination of Benefits
The Trustees have full authority and sole discretion to make determinations of entitlements to and amounts of Benefits. Subject to the right of appeal, the determination shall be final and binding upon all parties claiming Benefits under the Plan.

C. Medical Examination

No medical examination shall be required to obtain coverage for benefits initially. However, the Trustees have the right, through a medical examiner of their choosing, to examine a Covered Person as often as they may reasonably require during the pendency of a claim and the right and opportunity to request an autopsy in case of death where it is not forbidden by law.

D. Employer Rights to Contributions

Except in the case of mistaken contributions, the Employers shall have no right, title or interest in the contributions made by them to the Fund and no part of the Fund shall revert to the Employers in the event of a termination of the Fund.

E. Encumbrance of Benefits

No monies, property or equity of any nature whatsoever in the Fund, policies, Benefits or monies payable therefrom, shall be subject in any manner by a Covered Person or person claiming through a Covered Person, to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, garnishment, mortgage, lien or charge and any attempt to cause any benefit to be subject thereto shall be null and void; provided however, that Benefits may be assigned by the Covered Person or Beneficiary to the health care provider who furnished the services or supplies for which a benefit is payable.

F. Facility of Payment

Whenever payments which should have been made under this Plan in accordance herewith have been made under any other plans, the Trustees have the right, exercisable alone and in their sole discretion, to pay to the other organization making such payments any amounts which they determine to be warranted in order to satisfy the intent of this provision. Any amounts paid shall be deemed to be Benefits paid under this Plan and the Trustees shall be fully discharged from any future liability.

G. Reciprocity and Portability

The Trustees may enter into or amend portability or reciprocity agreements with other welfare funds.

H. Termination of Plan

The Benefits provided under this Plan are NOT vested benefits and the Trustees have the authority to terminate any benefit, including Retiree Benefits, or the entire Plan, at any time.

In the event of termination of the Plan, the Trustees shall apply the Fund to pay or provide the payment of any and all obligations of the Fund and shall distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purposes of the Fund. No part of the corpus or income of the Fund will be used for or diverted to purposes other than for the expenses of the Fund or for other payments in accordance with the provisions of the Fund. Under no circumstances will

any portion of the corpus or income of the Fund, directly or indirectly, revert to or accrue to the benefit of the Employers, the Association or the Union.

I. Right to Release or Request Information

For the purpose of determining the applicability and implementing the Coordination of Benefits and/or Subrogation provisions or any similar provisions in other plans, to the extent allowed by law, the Trustees may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person, any information with respect to any person which the Trustees deem necessary for such purposes. In so acting, the Trustees shall be free from any liability that may arise in relation to such action. Any person claiming Benefits under this Plan must furnish such information as the Trustees may reasonably deem necessary in order to implement this provision.

THE TRUSTEES WILL HAVE NO OBLIGATION TO FURNISH ANY BENEFIT UNDER THE PLAN UNTIL ALL ADDITIONAL INFORMATION REQUESTED HAS BEEN RECEIVED.

J. Subrogation of Benefits

In the event the Plan provides benefits for injury, Sickness or other loss (hereinafter the "Injury") to any Covered Person, the Plan is automatically subrogated to all rights of recovery to any funds or monies that person, his spouse, dependents, parents, heirs, guardians, conservators, next friend, executors, assigns, personal representative or other representatives (individually and collectively called the "Subrogation Covered Person") may have arising out of said injury, Sickness or other loss. Said recovery shall not be limited by characterization of loss and shall include recovery for personal injury, lost wages, loss of service, disability and claims for wrongful death, survivor or other claims under any state or federal law. The Plan is not limited or bound by any judgment or settlement that apportions recovery among the various elements of damage. The Plan shall automatically have a first priority lien and shall be entitled to first dollar reimbursement from any recovery regardless of whether the Subrogation Covered Person is made whole by said recovery. The Plan shall be entitled to assert a lien against third parties, insurers, attorneys and other appropriate person or entities admitted, determined and/or alleged to be liable to the Subrogation Covered Person in order to protect its right of subrogation.

This right of subrogation is specifically and unequivocally pro tanto subrogation; that is subrogation from the first dollar received by the Subrogation Covered Person, and this pro tanto is specifically and unequivocally to take effect before the whole debt is paid to the Subrogation Covered Person. The Plan's subrogation rights include, without limitation, an automatic first priority lien upon the first dollar recovery from any judgment, settlement or payment of any kind to the Subrogation Covered Person by any party admitted, determined, and/or alleged to be liable to the Subrogation Covered Person as well as all rights of recovery of a Subrogation Covered Person to

any payments made by or on behalf of an admitted, determined and/or alleged to be liable party including, but not limited to, a recovery:

1. Against any person, insurer or other entity that is in any way responsible for providing compensation, indemnification or benefits for the injury;

2. From any fund, or policy of insurance or accident benefit plan providing No Fault, Personal Injury Protection (PIP) or financial responsibility insurance or coverage;

3. Under uninsured or underinsured motorist insurance;

4. Under motor vehicle medical payment insurance and;

5. Under specific risk accident and health coverage or insurance, including without limitation premises or homeowners medical payments insurance or athletic or sports "school" or "team" coverages or insurance.

These rights of reimbursement and subrogation are reserved whether the admitted, determined and/or alleged liability of a third party arises in tort, contract or otherwise. Regardless of how proceeds are designated, the Plan's rights shall attach to any full or partial judgment, settlement or other recovery.

The Subrogation Covered Person, or if a minor, the Subrogation Covered Person's parent or legal guardian, conservator or next friend shall execute and deliver such documents and papers (including, but not limited to a benefits Questionnaire, Subrogation Agreement and Authorization to Release Medical Information) to the Fund Office as the Plan may require to protect its rights of reimbursement and subrogation. The Subrogation Covered Person shall do whatever else is necessary to protect the rights of the Plan, including allowing the intervention by the Trustees or Plan in any claim or action against the admitted, determined and/or alleged to be liable party or parties.

The Trustees are vested with full discretionary authority to determine eligibility for Benefits, to construe subrogation and other Plan provisions and to reduce or compromise the amount of the Plan's recoverable interest where, in the sole discretion of the Trustees, circumstances warrant such action. No settlement, however, shall be binding on the Plan without the Plan's written approval thereof, and the Plan expressly reserves the right to collect the entire amount of its subrogation interest in all cases. The amount of the Plan's subrogation interest shall be deducted first from any recovery from any entity or source by or on behalf of the Subrogation Covered Person regardless of any common fund or make-whole doctrines. The amount payable to the Plan, pursuant to the subrogation right, shall not be reduced pursuant to the application of any common fund doctrine, any make-whole doctrine and/or any other common law/state law doctrine purporting to reduce the amount of the Plan's recovery.

The Plan reserves the right to initiate an action in the name of the Subrogation Covered Person or his guardian, conservator or next friend to recover its subrogation interest, and the Subrogation Covered Person or his guardian, conservator or next friend will cooperate fully with the Plan in such instances.

In the event of any failure or refusal by the Subrogation Covered Person (1) to execute the Subrogation Agreement or any other document requested by the Fund Office, or (2) to take any other action requested by the Fund Office to protect the interest of the Plan, the Plan may withhold payment of Benefits or deduct the amount of any payments made from future claims of the Subrogation Covered Person.

The Subrogation Covered Person shall not do any act or engage in any negotiations that would reduce, compromise or prejudice the Plan's rights to first recovery from any third party. In the event the Subrogation Covered Person recovers any amount by settlement or judgment from any person, party, corporation, insurance carrier, governmental agency or other party which is admitted, determined and/or alleged to be liable to the Subrogation Covered Person, (1) the Plan shall be repaid in an amount equal to the full amount of Benefits paid by the Plan and (2) no further Benefits for treatment or services related to the injury leading to the settlement or recovery will be paid by the Plan. If the Subrogation Covered Person refuses or fails to repay such amount, or otherwise interferes with the Plan's right to subrogation, the amount of the Plan's claim shall be deemed to be held in constructive trust, and the Plan shall be entitled to seek restitution, impose a constructive trust or seek any other equitable or legal action against the Subrogation Covered Person or other party. In addition, the Plan reserves the right to offset and/or deduct any amounts paid as Benefits against future claims submitted by the Participant and his Eligible Dependents.

The Plan shall not pay or be held responsible for any portion of the Subrogation Covered Person's legal fees or expenses related to any recovery whether by settlement or judgment. The Plan reserves the right to first dollar from any recovery to the full amount of Benefits paid by the Plan and hereby claims a first lien against the proceeds of any settlement or judgment and priority over any claim or lien of legal counsel, insurers or any other third party. The Subrogation Covered Person shall provide all of the above referenced parties with notice of the Plan's first right of subrogation. However, the Trustees may, in their discretion, agree to share legal fees and expenses with the Subrogation Covered Person or his guardian, conservator or next friend, provided any such agreement is established in writing.

The "make whole" rule, any similar state law doctrine or the "common fund" doctrine is specifically and unequivocally rejected. The Plan's right of first dollar subrogation or reimbursement applies regardless of whether the Subrogation Covered Person is made whole or receives a partial recovery and regardless of the characterization or application of any recovery. The subrogation and reimbursement provisions of the Plan will apply even in the absence of a written agreement. Any person who is

represented by counsel will give notice of the written agreement, and a copy thereof, to their counsel.

The Plan has the right to offset any pending or future claims against any recovery by the eligible individual or Eligible Dependent to the extent the recovery exceeds the unreimbursed Benefits paid by the Plan, even if no Benefits have been paid by the Plan. The Plan will also have a lien to the extent of the Benefits paid, which may be filed with any party alleged, determined, and/or alleged to be liable to the Subrogation Covered Person on account of the loss incurred.

If the Subrogation Covered Person, or his guardian, conservator or next friend does not attempt a recovery of the Benefits paid by the Plan or for which the Plan may be obligated, the Plan shall be entitled to institute legal action against the party or parties alleged, determined, and/or alleged to be liable to the Subrogation Covered Person in the name of the Plan or Trustees in order that the Plan may recover all amounts paid to or on behalf of the Subrogation Covered Person.

In an action brought by the Plan, the reasonable cost of recovery, including the Plan's attorneys' fees, shall first be deducted from any recovery by judgment or settlement against the party or parties deemed liable by admission, judicial and/or administrative determination, or allegedly liable to the Subrogation Covered Person. The Plan's subrogation interest, to the full extent of Benefits paid or due as a result of the occurrence causing the injury or Sickness, shall next be deducted with the balance paid to the Subrogation Covered Person.

K. Protections From Surprise Medical Bills

Under a federal law called the No Surprises Act, you have protection against surprise medical bills from Out-of-Network providers and facilities. This law mainly applies to Out-of-Network Emergency Services, services provided by Out-of-Network providers at Network facilities, and Out-of-Network Air Ambulance Services.

1. Out-of-Network Emergency Services

Covered Emergency Services are treated as In-Network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum, even if the services were received from an Out-of-Network Emergency Facility. This means you will be responsible for the network cost-share amount. The Plan will count any cost-sharing payments toward the In-Network deductible and the out of pocket maximum in the same manner it would count cost-sharing payments made for In-Network Emergency Services.

Your cost-sharing will be based on the Recognized Amount payable for these services.

If you receive Emergency Services from an Out-of-Network provider, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and copayments, coinsurance, or deductible amounts paid by you.

2. Out-of-Network Providers at Network Facilities

Unless you consent to receiving services from the Out-of-Network provider (as described in subsection K4 below), covered services performed by Out-of-Network providers at In-Network hospitals or ambulatory surgical centers are treated as In-Network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum. This means you will be responsible for the network cost-share amount, and the Plan will count any cost-sharing payments incurred for these services toward the In-Network deductible and/or the out-of-pocket maximums under the Plan in the same manner it would count cost-sharing payments made for In-Network services.

Your cost-sharing will be based on the Recognized Amount payable for these services.

If you receive services from an Out-of-Network provider at an In-Network facility, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, which include payments paid by the Plan and copayments, coinsurance, or deductible amounts paid by you.

3. Out-of-Network Air Ambulance Providers

Covered Air Ambulance Services are treated as In-Network for determining all cost-sharing amounts, including the coinsurance, copayments, deductible, and the out-of-pocket maximum. This means you will be responsible for the network cost-share amount and the Plan will count any cost-sharing payments incurred for covered Air Ambulance Services toward the In-Network deductible and/or the out-of-pocket maximums in the same manner it would count cost-sharing payments made for In-Network services.

Your cost-sharing will be based on the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

If you receive Air Ambulance Services from a Out-of-Network provider, the provider is not permitted to "balance bill" you for the difference between what the provider charges and the total amount collected by the provider, including payments paid by the Plan and copayments, coinsurance, or deductible amounts paid by you.

4. Waiving Surprise Medical Bill Protections

In certain limited circumstances, you can waive the balance billing and cost-sharing protections provided under the No Surprises Act. You may be able to waive these protections for (1) certain non-ancillary services from an Out-of-Network Provider at a Network Facility or (2) services from an Out-of-Network Emergency Facility or provider after you are stabilized. This can occur if you are notified by the Out-of-Network Provider that the provider does not participate with the Plan and you provide informed consent to be treated by the provider and waive the protections.

If you give informed consent to be treated by the Out-of-Network provider, then the Plan will treat these services as Out-of-Network. This means you will be subject to Out-of-Network cost-sharing, the provider can bill you for the balance directly, and the provider can balance bill you for the difference between what the provider charges and the amount paid by the Plan and the cost-sharing amounts paid by you.

You may not waive No Surprises Act protections for ancillary services provided by an Out-of-Network Provider in an In-Network facility. Ancillary services include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services, and items and services provided by an Out-of-Network provider if there is no In-Network provider who can furnish such item or service at such facility.

5. Plan Payment to Out-of-Network Providers at Network Facilities, Out-of-Network Air Ambulance Providers, and Out-of-Network Emergency Facilities

For claims subject to the No Surprises Act from Out-of-Network Providers at In-Network health care facility, Out-of-Network Air Ambulance Providers, and Out-of-Network Emergency facilities, the Plan will pay the provider or facility the Out-of-Network Rate minus any cost-sharing amounts (copayments, coinsurance, and/or amounts paid towards deductible) you paid.

6. Continuing Care

Under the No Surprises Act, if you are receiving care from an in-network provider that becomes out-of-network, you may have certain rights to continue your course of treatment if you are a Continuing Care Patient.

If you are a Continuing Care Patient and the Plan terminates its contract with your In-Network provider or facility or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the Plan, you will be notified of the change and informed of your right to elect to receive transitional care from the provider. You may choose to continue your course of treatment under the

same terms and conditions as would have applied for an In-Network provider for up to 90 days after the notice is provided or until you no longer qualify as a Continuing Care Patient (whichever is earlier). These providers cannot balance bill you during this time.

Termination of a contract includes the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Section Thirteen – Your Rights Under Federal Law

READ THIS SECTION CAREFULLY. This is the only way to ensure that you have the information you need to protect your rights and your best interests under this Plan.

Your ERISA Rights as a Participant

In 1974, Congress passed and the President signed the Employee Retirement Income Security Act, commonly referred to as ERISA. As a Participant of the BAC Local Union 15 Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

A. Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each Participant with a copy of this summary annual report.

Be informed that under the Health Insurance Portability and Accountability Act (HIPAA), the Plan must provide you with a "Certificate of Creditable Coverage" if you lose health care coverage under the Plan for any reason. This Certificate reports data on prior periods of health coverage under the Plan compiled in accordance with federal regulations. Participants should retain this "Certificate of Creditable Coverage" and submit it to a new employer if the new employer maintains a group health care Plan. The new employer may be required under federal law to credit such coverage toward any waiting period for coverage of pre-existing conditions under the new employer's plan.

Be informed that the Plan is in compliance with the non-discrimination requirements set forth in Section 2590.701-2 of the DOL's HIPAA regulations. These regulations state that a group health care plan may NOT establish eligibility rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental illness); (3) prior claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability (including conditions arising out of domestic violence); or (8) disability.

Be informed that under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict Benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48 hour or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours, as applicable. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan administrator.

Be informed that under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical Benefits with respect to mastectomies shall include medical and surgical Benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery Benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and (4) physical complications for all stages of mastectomy, including lymphedemas. Such surgery shall be in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's Schedule of Benefits, such Benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and Coinsurance.

B. Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Restated Plan Document and Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Exclusionary periods of coverage for pre-existing conditions under the Plan may be reduced or eliminated if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from this Plan (any other group health plan), or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

C. Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

D. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

However, all review and appeal procedures described in the Plan usually must be followed and exhausted before a Claimant may institute any legal action including any action or proceedings before any court, administrative agency or arbitrator ("legal bodies"). Generally, such legal bodies require a Claimant to follow and exhaust the Fund's review procedures before allowing a Claimant's legal action to proceed. If a Claimant files a legal action before following and exhausting the Fund's review procedures, this may result in a negative ruling by the relevant legal body and impair or cause the loss of the right to bring any further legal action.

E. Assistance with your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical

Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

Section Fourteen – Other Important Information

One of the main goals of the Employee Retirement Income Security Act of 1974 (ERISA) is expanded reporting and disclosure of benefit plan operations and provisions, that is, reporting to the Department of Labor, Internal Revenue Service and to the Plan Participants and Beneficiaries.

It is the intention of the Trustees to comply with all aspects of ERISA. Thus the required information in this Section has been reported to the appropriate federal agencies and is hereby "disclosed" to you.

A. Administration of Plan

The Plan is administered by a joint Board of Trustees, one-half of whom are appointed by the Union and one-half of whom are appointed by the Association. The Trustees have hired a contract administrative manager to perform the day-to-day operations of the Plan, such as maintaining records, making benefit payments and handling general administrative matters. The contract administrative manager is:

Wilson-McShane Corporation
PO Box 909500
Kansas City, MO 64190-9500
(816) 777-2668 or (833) 479-9428

B. Employer Identification Number

The Employer Identification Number assigned to the Plan by the Internal Revenue Service is 23-7386028.

C. Funding Medium for the Accumulation of Plan Assets

All contributions and investment earnings of the Plan are accumulated in a Trust Fund which is utilized to pay Benefits to eligible individuals and to defray reasonable costs of administration.

D. Name of Plan

The full legal name of the Plan is the BAC Local Union 15 Welfare Plan.

E. Plan Advisors

Fund Attorney (Person to Receive Service of Legal Process)
Mr. Bradley J. Sollars
Arnold, Newbold, Sollars & Hollins, P.C.
1100 Main Street, Suite 2001
Kansas City, MO 64105-5178

Service may also be made on any Plan Trustee or Plan Administrator.

Plan Consultant and Plan Actuary
United Actuarial Services, Inc.
11590 North Meridian Street, Suite 610
Carmel, IN 46032-4529

F. Plan Fiscal Year
April 1 of each year and ends on March 31 of the following year.

G. Plan Number
The Plan Number is 501.

H. Plan Year
April 1 of each year and ends on March 31 of the following year.

I. Sources of Contributions
This Plan is funded through contributions by the Employers on behalf of their Employees, under the terms of a Collective Bargaining Agreement, and by investment income earned on a portion of the Fund's assets. In some cases, a Covered Person will be entitled to make self-payments in order to maintain eligibility for Benefits.

J. Type of Plan
This Plan provides hospitalization, medical, death, accidental death and dismemberment, maternity, dental and other related health care benefits. It is maintained pursuant to a Collective Bargaining Agreement between the Union and the Association which is available for examination at the Fund Office. A copy of the agreement may be obtained upon written request to the Fund Office. Upon request, the Fund Office will also inform you if a particular employer or union participates in the Plan and, if so, the address of that employer or union.

K. Amendment
The Trustees reserve the right to amend, modify or terminate this Plan, or any Benefits, as circumstances dictate.

L. Medicare Retiree MAPD Support

MAPD Labor First Advocacy Team

for questions regarding medical and prescription benefits, medical providers, and pharmacies.	(816) 369-0019 (TTY 711) (833) 236-2089 (Toll Free) Monday-Friday 8:00am - 5:00pm CST
MAPD Plan Insurance Company:	**UnitedHealthcare** PO Box 31362 Salt Lake City, UT 84131-0362 (844) 481-8820 (TTY 711)

M. Grandfathered Health Plan

This Plan believes this health plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan administrative manager at the Fund Office.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Section Fifteen – Definitions

THE FOLLOWING WORDS HAVE SPECIFIC MEANINGS WHEN USED IN THE PLAN. IT IS IMPORTANT TO UNDERSTAND THE MEANINGS OF THESE DEFINED TERMS WHILE USING THIS BOOKLET.

A. Accident

The term **"Accident"** means a physical injury, such as a cut, break, sprain or bruise, occurring from an unexpected, undesirable and unavoidable act. This does NOT include overuse of muscles resulting in strains or aching arms and legs.

B. Air Ambulance Service

The term "**Air Ambulance Service**" means medical transport by helicopter or airplane for patients

C. Association

The term **"Association"** means The Builders' Association

D. Beneficiary

The term **"Beneficiary"** means a person designated by an Employee or by the terms of the Plan of Benefits established pursuant to the Trust Agreement who is, or who may become, entitled to receive any type of benefit from the Fund. When a benefit is payable to a Beneficiary, it will be paid to the Employee-designated Beneficiary on file at the Fund Office. In the event the Employee fails to designate a Beneficiary or if the designated Beneficiary dies before the Employee, the benefit shall be payable to the first of the following, if living:

1. To the legal spouse, or

2. If no legal spouse is living, to the living children in equal shares, or

3. If no legal spouse or children are living, to the living parents in equal shares, or

4. If no legal spouse, children or parents are living, to the living brothers and sisters in equal shares, or

5. If none of the above are living, to the Employee's estate.

The Employee may designate a new Beneficiary at any time by filing a written request with the Fund Office. If an Active Employee names his/her Spouse as his/her Beneficiary and then the Active Employee and Spouse subsequently divorce, that Beneficiary designation is void and of no effect. If the Active Employee desires to name his/her ex-spouse as his/her Beneficiary, the Active Employee must fill out another Beneficiary designation form after the divorce.

E. Benefits

The term **"Benefits"** means the Health and Welfare benefits to be provided pursuant to the Plan together with any amendments, modifications or interpretations adopted by the Board of Trustees.

F. COBRA Continuation Coverage

The term **"COBRA Continuation Coverage"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, and any amendments thereto and any governmental regulations, guidance or interpretations issued thereto, requiring that health and welfare plans offer employees and their families the opportunity for a temporary extension of health coverage.

G. Collective Bargaining Agreement

The term **"Collective Bargaining Agreement"** means the labor agreement between the Union and the Association and any other employer, group of employers or association of employers.

H. Continuing Care Patient

The term "**Continuing Care Patient**" means a patient that

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. is undergoing a course of institutional or inpatient care from the provider or facility'
3. is scheduled to undergo nonelective surgery from the provider, including receipt of
   postoperative care from such provider or facility with respect to such a surgery;
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. is or was determined to be terminally ill (as determined under Social Security Act) and is receiving treatment for such illness from such provider or facility.

For the purposes of this definition of "Continuing Care Patient", "serious and complex condition" means:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm;
- in the case of a chronic illness or condition, a condition that
  - is life-threatening, degenerative, potentially disabling, or congenital; and
  - requires specialized medical care over a prolonged period of time.

I. Contributions

The term **"Contributions"** means the money paid to the Fund by Employers in accordance with the provisions of the Collective Bargaining Agreement(s).

J. Covered Employee

The term **"Covered Employee"** means an employee for whom Contributions are made to the Fund as provided by a Collective Bargaining Agreement or other written agreement approved by the Trustees and who is covered according to the provisions set forth under the Eligibility Rules.

K. Covered Person

The term **"Covered Person"** means either the Covered Employee or Retiree and their Eligible Dependents.

L. Eligible Dependent

The term **"Eligible Dependent"** means any of the following:

1. The lawful spouse of the Covered Employee or Retiree (not legally separated or divorced).

2. The natural or adopted children (or placed for adoption) or stepchildren of the Covered Employee or Retiree, as defined below:

   a. who are:

      i. under the age of 26; or

      ii. Totally Disabled; and

   b. Other minor children, for whom the Covered Employee or Retiree has been appointed by the court as legal guardian as well as been required to provide medical coverage for the children, who are:

      i. under the age of 26; or

      ii. Totally Disabled.

   c. The term "placed for adoption" means the assumption and retention by a Covered Employee or Retiree of a legal obligation of a child in anticipation of the adoption of the child prior to that child's 18th birthday. The child's placement with the Covered Employee or Retiree ends upon the termination of such legal obligation.

   d. Totally Disabled children who are disabled because of a qualifying physical or mental handicap under this definition. In order to qualify, the physical or mental handicap must:

      i. occur before the child reaches age 19;

      ii. be certified by a Physician; and

      iii. render the child incapable of self-sustaining employment so as to make the child dependent upon the parents for financial support and maintenance. Initial proof of such disability and financial dependence must be furnished to the Board of Trustees within 31 days of the child's reaching 19 years of age. Subsequent proofs may be required by the Board of Trustees after the child reaches age 21, but not more frequently than annually.

3. Children for whom coverage must be provided because of a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order, administrative order pursuant to state law or court decree relating to child support under the Plan. The Fund Office shall be delegated the authority to determine if a National Medical Support Notice, issued by a state agency pursuant to ERISA Section 609, 20 USC Section 1169 and the regulations promulgated therefrom, constitutes a QMCSO. QMCSOs other than National Medical Support Notices

must be approved by the Board of Trustees to be qualified. A copy of the Plan's QMCSO qualification procedures is available from the Fund Office upon request.

4. For dependents working full-time under the age of 26 and having their own health care coverage, this Plan will coordinate and be the secondary payer. In the event that two Employees are married to each other, Benefits will be paid at the rate of 80% as an Employee and an additional 20% as an Eligible Dependent.

M. Eligibility Rules

The term **"Eligibility Rules"** applies to active Employees and their Eligible Dependents, retired Employees and their Eligible Dependents, total and permanently disabled Employees and their Eligible Dependents, and Employees and Eligible Dependents under COBRA Continuation Coverage.

N. Emergency or Emergency Medical Condition

The terms "**Emergency**" or "**Emergency Medical Condition**" means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

O. Emergency Services

With respect to an Emergency Medical Condition, "**Emergency Services**" means:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition
2. Such further medical examination and treatment to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department
3. Further services that are furnished by an Out-of-Network provider or Out-of-Network Emergency Facility after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay (regardless of the department of the hospital in which such further examination or treatment is furnished).

P. Employee

The term **"Employee"** means:

1. Any person who is employed by an Employer, as that term is defined in the Plan, and for whom the Employer is required to make contributions into the Trust Fund;

2. Any full time employee of the Union or of a participating union;

3. Any full time employee of the Association;

4. Any full time employee of the Board of Trustees; and

5. Any other employee of any Employer who has been accepted as such by the parties to the Trust Agreement.

Q. Employer

The term **"Employer"** means:

1. Any member of the Association who is a party to, or otherwise bound by a Collective Bargaining Agreement with the Union requiring Contributions to the Trust Fund with respect to employees represented by the Union.
2. Any employer who has signed a Stipulation in accordance with Annex "A" of the Trust Agreement or in a form otherwise approved by the Board of Trustees.

3. Any other employer, association of employers or group of employers who have been accepted and approved by the Board of Trustees.

4. The Trustees as to its Employees, the participating unions as to Employees of participating unions, the Association as to Employees of the Association, and related funds as to the Employees of the related funds. Such status of the Union, participating unions, the Trustees and related funds shall be solely for the purpose of making the required contributions to the Trust Fund.

R. ERISA

The term **"ERISA"** means the Employee Retirement Income Security Act of 1974, any amendments as may from time to time be made, and any regulations promulgated pursuant to the provisions of said Act.

S. Expense Incurred

The term **"Expense Incurred"** includes only those charges made for services and supplies which are reasonably priced and are appropriate and consistent with the diagnosis according to accepted standards of community practice, and could not have been omitted without adversely affecting the person's condition or the quality of medical care. All Expenses Incurred will be considered on a Usual, Customary and Reasonable Charge basis in the given geographical area which shall be no higher than the 90^{th} percentile of prevailing health care charges data.

T. Hospice

The term **"Hospice"** means a licensed agency that provides counseling and medical services to the terminally ill and which meets **all** of the following tests:

1. Has obtained any required state or governmental Certificate of Need approval,

2. Provides services on a 24 hour, seven day a week basis,

3. Is under the direct supervision of a Physician,

4. Has a nurse coordinator who is a Registered Nurse (R.N.),

5. Has a social service coordinator who is licensed,

6. Is an agency that has as its primary purpose the provision of Hospice services,

7. Has a full time administrator,

8. Maintains written records of services provided to the patients, and

9. Is licensed in the jurisdiction in which it is located, if licensing is required.

U. Hospital

1. The term **"Hospital"** means only a facility which meets **all** of the following criteria:

   a. operates pursuant to law;
   b. Provides 24-hour nursing services by Registered Nurses (R.N.s) on duty or call; and
   c. Provides Health Care services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities by or under the supervision of a staff of physicians.

2. Hospital does not include health resorts; nursing homes; Christian Science sanitoria; institutions for exceptional children; places that are primarily for the care of convalescents; clinics; Physicians' offices; private homes; ambulatory surgical centers; or Hospices.

3. For purposes of Alcohol and Drug Treatment Benefits and Mental Health Benefits, Hospital means, (a) facilities or institutions as defined in Subsection 1, above; or (b) a facility licensed by the appropriate state governmental authority and certified under Medicare as a participating hospital for the treatment of mental and nervous disorders or alcohol or substance use disorders.

V. Independent Freestanding Emergency Department

The term "**Independent Freestanding Emergency Department**" means a health care facility that (1) Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and (2) Provides any "Emergency Services" as defined in this document.

W. In-Patient

The term **"In-Patient"** means a person who is a resident patient using and being charged for the room and board facilities of a Hospital.

X. MAPD

The term **"MAPD"** means a Medicare Advantage with Part D policy which provides benefits under the Plan for all eligible Medicare-eligible Retirees and spouses.

Y. Medically Necessary

The term **"Medically Necessary"** means only those services, treatments or supplies provided by a Hospital, a Physician, or other qualified provider of medical services or supplies that are required, in the judgment of the Trustees based upon the opinion of a qualified medical professional, to identify or treat a Covered Person's Accident or Sickness and which are:

1. Appropriate and necessary for the symptoms, diagnosis and treatment of the Covered Person's condition, disease, ailment or injury,

2. Consistent with acceptable medical practice according to the medical policy established by the national Blue Cross and Blue Shield Association (the right to review this medical policy is available upon review of a denied claim in accordance with terms of Section X,

3. Not primarily for the convenience of the Covered Person, his family, Physician or other provider,

4. Consistent with attaining reasonably achievable outcomes,

5. Not deemed to be Experimental, Investigative or Inappropriate, and

6. Reasonably calculated to result in the improvement of the Covered Person's physiological and psychological functioning.

The fact that a Physician prescribes services or supplies does not automatically mean the services or supplies are Medically Necessary and covered by the Plan.

For purposes of this Plan, the use of any treatment (which includes use of any treatment, procedure, facility, drug equipment, device, or supply) is considered to be "Experimental," "Investigative" or "Inappropriate" if:

1. It is a service or treatment on which the consensus of expert medical opinion, based on Reliable Evidence (i.e., published reports and/or articles), indicates that further trials or studies are needed to determine the safety, efficiency and outcomes of such treatment or services compared to standard treatment. Experimental, Investigative or Inappropriate also means such services or treatment snot yet official and not yet recognized as having proven beneficial outcomes, those still primarily confined to a research setting and those that are not appropriate based on medical circumstances and/or given the advanced stage of a Covered Person's Sickness or the likelihood that the service or treatment will measurable improve the Covered Person's Sickness or the likelihood that the service or treatment will measurably improve the Covered Person's Sickness or medical condition,

2. The drug or device cannot be lawfully marketed without the US Food and Drug Administration approval and that no approval for marketing has been given at the time the drug or device is furnished,

3. Reliable Evidence shows the drug, device, treatment or procedure is:

    a. The subject of ongoing Phase I or Phase II clinical trial, the experimental or research arm of a Phase III clinical trial, or in any other manner with the objective of evaluating the maximum tolerated dosage, toxicity, safety or efficacy,

    b. Provided following a written protocol or other document with the objective of evaluating the toxicity, safety or efficacy, or

    c. Experimental or Investigative based on the patient's informed consent document used with the drug, device or medical treatment,

4. The uniform medical policy of the national Blue Cross and Blue Shield Associate (as amended from time to time) has determined that the device or medical treatment/procedure is investigational based on:

    a. Not receiving final approval from the appropriate governmental regulatory bodies,

    b. Scientific evidence does not permit conclusions about the effect of the device of medical treatment/procedure on health outcomes,

    c. The device or medical treatment/procedure does not improve the overall health outcome,

    d. The device or medical treatment/procedure is not as beneficial as established alternatives, or

    e. The improvement is not attainable outside the investigational settings.

Reliable Evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocol used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure.

The Trustees will have the sole authority to determine, in their discretion, whether a service, procedure, drug, device or treatment modality is Experimental, Investigative or Inappropriate. The fact that a Physician has prescribed, ordered, recommended or approved the service, procedure, drug, device or treatment does not, in itself, make it eligible for payment.

Z. Out-of-Network Emergency Facility

The term "**Out-of-Network Emergency Facility**" means an emergency department of a hospital, or an Independent Freestanding Emergency Department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with the Plan, with respect to the furnishing of an item or service.

AA. Out-of-Network Rate

The term "**Out-of-Network Rate"** will be determined in the following order:

1. the amount that the state approves under an All-Payer Model Agreement, if applicable
2. the amount determined by a state law, if applicable;
3. the payment amount agreed to by the Plan and provider or facility, if applicable;
4. the amount approved under the independent dispute resolution (IDR) process

BB. Out-Patient

The term **"Out-Patient"** means a person who receives services and treatments in a Hospital (provided that there is no charge for room and board), ambulatory clinic, free-standing surgical unit, or Physician's office.

CC. Participant

The term **"Participant"** means an Employee or former Employee of an Employer who is eligible to receive any type of Benefit from this Fund.

DD. Physician

The term **"Physician"** means medical doctors, osteopaths, surgeons, dentists, podiatrists, chiropractors and psychologists with a Ph.D., when practicing within the scope of their license.

EE. Plan

The term **"Plan"** means the Schedule of Benefits and the rules and regulations of the BAC Local Union 15 Welfare Fund and the Trust Fund as established heretofore, or

as shall be established from time to time by amendments, modifications or interpretations by the Trustees for the administration of the Trust Fund and Plan.

The Plan was established as of April 5, 1973, in accordance with the provisions of the Trust Agreement.

FF. Preventive Services

The term "**Preventive Service**" means:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except as provided below;

2. Immunizations for routine use in children, adolescents and adults that have a recommendation in effect from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

4. With respect to women, to the extent not already included in recommendations from USPSTF, evidence-informed preventive care and screenings provided for in comprehensive guidelines by the Health Resources and Services Administration.

GG. Qualifying Payment Amount (QPA)

The term "**Qualifying Payment Amount**" means generally, the median amount the Plan has contractually agreed to pay network providers, facilities, or providers of Air Ambulance Services for a particular covered service. This amount is updated annually to account for inflation.

HH. Recognized Amount

The term "**Recognized Amount**" means for items and services furnished by an Out-of-Network provider or Out-of-Network Emergency Facility, an amount determined in the following order:

1. An amount determined by an All-Payer Model Agreement, if applicable
2. An amount determined by a specified state law, if applicable;
3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount

II. Retiree

The term **"Retiree"** means a Covered Employee who has retired from active employment and who meets the eligibility requirements for Retirees as explained in Section Two E.

JJ. Sickness

The term **"Sickness"** includes mental or physical illness, pain or a fever not caused by an Accident.

KK. Subrogation Covered Person

For the purpose of Section Twelve J, the term **"Subrogation Covered Person"** means a Covered Person, his spouse, dependents, parents, heirs, guardians, conservators, next friend, executors, assigns, personal representative or other representative.

LL. Totally Disabled

The term **"Totally Disabled"** unless otherwise specifically defined, refers to a disability resulting solely from a Sickness or Accident which prevents the Covered Employee from performing Bricklayer and Allied Crafts work as defined in the work jurisdiction definition of the Collective Bargaining Agreement or prevents the Covered Employee's dependent(s) from engaging in substantially all of the normal activities of a person of like age and sex in good health. Both the Covered Employee and the Covered Employee's Eligible Dependent(s) must be under the regular care and actual attendance of a Physician.

MM. Trust Agreement

The term **"Trust Agreement"** means the amended Agreement and Declaration of Trust effective January 1, 1976, including the original Trust Agreement.

NN. Trust Fund

The term **"Trust Fund"** means the Trust Fund created pursuant to the Trust Agreement and generally the monies or other things of value which comprise the corpus and additions to the Trust Fund.

OO. Trustees

The term **"Trustees"** (or **"Board"** or **"Board of Trustees"**) means the persons designated in the Trust Agreement, their predecessors or their successors designated and appointed in accordance with the terms of the Trust Agreement. The Trustees shall constitute the "Administrator," the "Plan Sponsor" and the "Named Fiduciaries" of the Trust Fund and of the Plan established and maintained under the authority of the Trust Agreement.

PP. Union

The term **"Union"** means Local 15 of the International Union of Bricklayers and Allied Craftworkers, AFL-CIO, and other BAC Unions which may become parties to the Trust.

QQ. Usual, Customary and Reasonable Charge (UCR Charge)

The term **"Usual, Customary and Reasonable Charge (UCR Charge)"** means that the charge by any provider for a service must be similar to all other like providers of the same service in that geographical area and which is no higher than the 90th percentile of prevailing health care data on such charges. The "geographical area" reference is the zip code for the general level of charges being made by a Physician of similar training and experience. For In-Network providers, the allowed charge is the UCR Charge.